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THE FUNDAMENTAL NEEDS OF THE CHILD *

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EVERY society and every generation uses children for its own purposes. It is significant that to-day we are beginning to speak of the needs of the child as entitled to consideration in his nurture and education or even as the controlling factor in child care. Contrast this emerging conception of the child's nature and needs with the practices all over the world, among so-called civilized people and so-called primitive people, in which the nurture and education of children are dictated by religious, ethical, and moral ideas, by political and economic requirements, by social class lines, indeed by an extraordinary variety of ideas and purposes all more or less remote from the child himself. The children in all these cultures are molded by the dominant ideas and beliefs and the group purposes into greater or less conformity in which they may sacrifice much or little.

Consider also the variety of practices in regard to the physical make-up or form of children. Among certain Indian tribes, the infant's head is flattened to a board. Among certain African tribes, the lips or ears may be stretched or the neck encased in coils of brass. Every one is familiar with the ancient Chinese practice of binding the feet of female infants. As children grow older, many peoples have puberty rites involving tattooing, skin incisions, various forms of mutilation of the male and female genitals, and the inculca-

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tion of rigidly prescribed motor patterns of action that may involve anatomical deformities. The catalogue of practices that deform, distort, or otherwise manipulate the physical structure is endless, but all are regarded by those who use them as essentially necessary to make over the child into the image prescribed by the culture as the only right form for a man or a woman. In their cultural context these practices and beliefs may be purposeful and valid.

Not only is the physical structure of the child made over into the patterns of the culture, but so are the physiological functions, as we see in the diverse standards imposed upon the young child by different societies. In the matter of nutrition, for example, every group teaches the child to like the food of its traditional choice, which means developing an appetite for an incredible array of foodstuffs, or supposed foodstuffs, and abhorring other foodstuffs of equal or greater nutritive value. Many of these food choices represent a wise, economical use of available animal and vegetable resources, while others are obviously dictated by various beliefs in sympathetic magic, by rigid taboos, and by religious convictions that have little or no relation to the nutritional requirements of the growing child or even of the adult. Every society, again, imposes some kind of training upon children with respect to elimination. In some cultures the requirements are minimal, but in others they may be so severe and so rigorously imposed upon the very young child as to create lifelong impairment of physiological efficiency. Even breathing, in some cultures, is subject to special training, and sleeping patterns, peculiar to each group, are inculcated at an early age.

It is safe to say that most of these traditional patterns of child training and nurture derive from ideas and beliefs and strong convictions that have little or no relevance to the immediate needs of the child. Civilized man in many cases has survived *despite*, not because of, these methods of child care, as we are now beginning to realize in the light of recent investigation.

Curious as are these practices of physical and physiological training, the variety of practices in psychological training are even more astonishing, since here we find methods and

procedures for bringing up children in the most fantastic, distorted patterns of conduct and feeling. The belief in using the child for social purposes is revealed here more convincingly than in the realm of physical care, where the organic limits of deformation impose some restraint; whereas in the area of conduct and belief there apparently are no limits to the grotesque, the cruel and brutal, the diabolical ingenuity of man in warping and twisting human nature to cultural patterns which originally may have been useful or even desirable, but which have become rigid and perverse.

When we reflect upon these various beliefs and practices that are imposed upon the child to make him conform to group-sanctioned patterns, we can begin to understand how extraordinarily significant it is to-day that we are discussing the needs of the child as a basis for his nurture and education. We can also see how questions of education and training become the focus of bitter conflicts, as contending factions in a society struggle to direct the nurture of children in order to control the group life. As we meet to-day to discuss programs of education for the young child in the home and in the nursery school, we are not concerned merely with questions of technique and procedures, with this or that pedagogical device; we are faced with the major issues of the future of our culture and the direction of our whole social, economic, and political life, since an effective program of early-childhood education based upon the needs of the child will inevitably change our society far more effectively than any legislation or other social action.

We must, therefore, be humble and deliberate in our discussion, not only because of the gravity of the larger social issues involved, but also because we know so little about the needs of the child. It is safe to say that whenever you hear any person or group speaking with strong convictions about specific needs of the child and how to meet them, that person or group is probably sustained more by emotional fervor and loyalty to cultural traditions than by dependable knowledge of actual children.

Any one who is prepared seriously and fairly to consider the question of the child's needs must begin by trying to be honest about his or her own personality bias and beliefs, emo-

tional attitudes, religious loyalties, and social-economic and political leanings, because these often unconscious feelings and values play so large a rôle in our attitudes toward the child and in our willingness to recognize some of his needs or our strong denial of them. Probably the most general statement that we can make about the child's needs is that he should be protected from distortions, from unnecessary deprivations and exploitations by adults—parents, teachers and nurses, physicians, psychologists, and others engaged in dealing with children.

It is difficult to realize the extent of these often subtle coercions and pressures exerted upon the child. Before the infant is born, the parents may have built up a picture of the kind of child he or she is to be, with a pronounced bias toward the male or the female sex, or toward a certain kind of temperament, physique, and ability. The infant, having within him the genes of countless previous generations as well as the characteristics of his parents, enters into a family situation that even at birth may be threatening and out of harmony with his peculiar, idiosyncratic temperamental make-up and needs. Parents who are eager to minister to the infant's need for warmth, food, and safety may be doggedly determined to deny the child's sex and his many personal, temperamental characteristics, which give rise to needs as important and urgent as the need for physical care.

It is not without reason, therefore, that we stress this primary and inalienable need of the child to be accepted as a unique individual, or, if the parents cannot or will not accord that acceptance, the need to be protected and reinforced against the destructive, warping influence of these parental biases. Every child suffers to a greater or less extent from this denial of his own personal, temperamental individuality, because even the most emancipated parents are not wholly free from the desire to see their children conform to the images they have constructed. Moreover, every teacher has these partialities, often unconscious, which incline her toward one child and away from another. Further, the child himself is subject to the strong desire to be like the parents, however out of harmony with his own make-up such an identification may be. It is interesting to see how the recognition of indi-

vidual differences is resisted even by professionally trained persons, such as teachers, who will accept the fact of such differences with respect to mental capacity, as shown by standardized mental tests, but deny it with respect to personality, temperament, physical maturity, and other obvious characteristics.

The infant, as he grows into childhood and youth, faces a series of life tasks that cannot be evaded or denied. The way in which he meets those life tasks and his attempts to master them give rise to the various needs for which we to-day believe his nurture and education should provide. It is obvious that we have only a fragmentary knowledge of those needs, since we have studied so briefly the process of growth and development and the life tasks presented by our culture. But it is highly significant, as we suggested earlier, that we are genuinely concerned with understanding child growth and development and are trying to discover the child's needs, as a basis for his education and nurture.

The processes involved in living and growing create needs for warmth, nutrition, and bodily care concerning which we are gaining more knowledge and technical competence. Much of the research in the field of nutrition and its results are still in terms of uniform standardized rules based on pure-strain rat colonies, with no allowance made for individual differences in vitamin and mineral requirements, so that, in the name of scientific standards, we may create serious deficiencies in the individual child as contrasted with the standardized laboratory animal. Even rats in the same litter differ, as Streeter has recently shown, in their susceptibility to rickets. The nutritional and other physical needs of the individual child are to be viewed dynamically, not statically, in terms of continuing growth and development rather than fixed height-weight standards which are purely statistical averages. Moreover, these needs should be viewed in terms of physiological functioning, not merely of structural size and shape, since it is functional efficiency, not structure, that is important.

How many problem children, hypochondriacs, and psychoneurotics have been created by blind adherence to these standardized tables which physicians and nurses, health edu-

cators, and teachers have given to mothers as scientific laws and which mothers have then used on their children! Surely we should allow for individual differences in children and not increase parental anxiety in this area of physical needs by insisting upon these standardized height and weight tables for chronological-age groups. The child's need is for food, rest, sleep, and play, so that he will continue to grow and develop *at his own rate*. The emphasis should be upon the growing, not upon fixed dimensions for chronological ages based upon the assumption that all children grow at the same rate.

The same criticism may be made of other chronological-age standards, such as prescribed hours for sleeping, where again failure to make allowance for individual differences has created many distraught mothers and problem children. The sleep needs of children vary greatly, and the loss of a nap is often much less undesirable than conflict, rebellion, punishment, and other consequences of a rigid sleep regimen.

If we are to gain a better understanding of the child's needs in terms of the life tasks he faces, we should envisage the physiological processes involved in what we call socialization. First in order of impact upon the infant is the regularization of feeding, involving a fixed interval of three or four hours between food intake, to which the infant must adapt despite individual differences in the reduction of blood sugar that creates hunger and in the capacity to endure hunger. Prolonged hunger and crying, often while the mother keeps her eye on the clock to see when the precise minute for feeding arrives, create in the child a condition of tension that may in some cases initiate persistent personality difficulties.

In feeding we are confronted with something more than just a need for nourishment. In early infancy, the whole body of the infant is receptive and in need of comforting, cuddling warmth and opportunity to suckle. In breast-feeding these needs may be adequately filled, through the warmth of the mother and the close tactual contact with her through nourishment and suckling, wherein the baby receives much of his needed sense of security and feeling of being protected. Tactual contacts and soothing are primitive, but highly necessary forms of reassurance. We never outgrow the need of

them, but it is especially great in infancy and childhood. In this respect the human infant is like the young of all mammals, who thrive when nursed and cuddled and derive much needed emotional security from the oral activity of sucking and the close contact with the mother.

By many students of personality, it is said that if the infant is given adequate breast-feeding and affectionate cuddling, his future attitude toward the world will be outgoing, generous, and trusting, whereas if he is denied these satisfactions, he will be suspicious, niggardly, and resentful. Dr. David Levy is quoted with approval by Dr. James S. Plant [1] as stating "that satisfactory breast-feeding [cuddling] experiences do more than whole dictionaries of later words in the establishment of security in the family group"—what Dr. Plant calls "belongingness." Since so many children nowadays are deprived of breast-feeding, it is necessary to consider the acceptance of that deprivation as a life task that is imposed upon the dependent infant, thereby creating specific needs which may persist throughout life. The seriousness of this deprivation could be diminished if the bottle-fed infant were held by the mother and cuddled while taking the bottle, so as to receive the warmth and security of her close presence during the feeding.

But even the breast-fed infant must sooner or later lose that happiness and comfort and face the process of weaning, which may create anxiety and irritability if too abruptly or roughly handled. During weaning the child needs additional reassurances and comforting to prevent acute feelings of insecurity and anxiety and to lessen the loss of sucking. Every deprivation is a threat to the child, a source of anxiety which can be mitigated by affectionate reassurance which makes him feel that the deprivation is not a punishment and that he is still loved. The important question for nursery schools to ask is what can they do for the children who have been deprived of breast-feeding or unwisely weaned, and who need to be reassured and protected, helped to outgrow their anxiety, and aided with affectionate reassurance.

Eliminations and their regularization present two more life

[1] In *Personality and the Cultural Pattern*. New York: The Commonwealth Fund, 1937.

tasks that may create persistent needs. In discussing and teaching toilet training, we are apt to forget what a profound physiological disturbance we are imposing on the child. The physiological processes of elimination of urine and feces are marvelously well organized, so that automatically the sphincters of the bladder and the rectum respond to accumulated pressure within. This physiological autonomy the child is asked to surrender when toilet training begins. Instead of functioning in accordance with his physiological needs, he is asked to inhibit the sphincter response to pressure, responding instead to an external stimulus—vessel, place, and so on—presented by the adult. Furthermore, he is asked to respond at a fixed time, whether or not he needs to do so physiologically. In this training, the child is expected to subordinate his processes to outside events and times, giving up his own physiological autonomy, often months before he is sufficiently mature to make such an adjustment. Maturity does not mean chronological age or size or weight; it means that the child has had enough of an activity, such as sucking or unrestricted elimination, to be able to go on to something else without a persistent feeling of deprivation or an unsatisfied infantile longing.

The widespread prevalence of enuresis and of constipation are not unrelated to the way in which toilet training has been imposed upon children who find in this process a serious nervous and emotional strain. During toilet training the child needs constant reassurance and comforting to stand the anxiety he so often feels. When failure to be continent elicits scoldings and punishment, the emotional stresses are increased and reinforced by feelings of guilt and inadequacy, often expressed in various symptoms of misbehavior. Evidence of how precariously the little child is balanced during toilet training is seen in the relapses that follow any emotional shock or family disturbance, or in the appearance of misconduct suddenly in the midst of peaceful, engrossing play, when the child is made uneasy and restless by a full bladder of which he is not yet fully aware. The evident over-concern of parents and nurses with toilet training raises for nursery schools the question what they can do to provide reassurance for the anxious child, and to make toilet functions an unemo-

tional subject and action. It is probable that some nursery schools themselves are guilty of aggravating the child's insecurity by their rigid overemphasis upon toilet training and the fuss made over "slips" or the teachers' unconscious reaction toward feces.

Here it is necessary to point out that the emotional tone or attitude of parents, nurses, and teachers toward toilet training is the important thing, not their actions, for the child reacts to the tone or attitude and feels the tenseness or overemphasis or dislike in the adult's voice and handling. The importance of the manner and tone of voice lies in the child's feeling that he is being deprived by this training. Any anger or impatience, then, may become an occasion for anxiety and feelings of guilt. How else is the child to understand and interpret the adult's treatment of him? Since many adults carry over from their own childhood a feeling of anxiety or disgust at feces, it is clear that they are not able to treat the child under their care without emotional stress when faced with this process, which for the child is entirely normal and unconnected with emotion until adult interference begins. Since few children pass through toilet training without some stress, we may include among the needs of the child the need for reassurance and often for release from the effects of this process upon the personality. It is appropriate to raise the question about toilet training: Are we concerned only with character training and the conformity it implies, or are we concerned with personality development and the kind of human being we are helping to foster? We can instill good habits or foster a personality; in the latter case, the habits will usually be established without difficulty. Weaning and toilet training, as often handled, are important sources of personality twists and biases, and may give rise to persistent needs in the child.

The arrival of a younger child in the family also may create acute anxiety when the older child has not been prepared for it. The shock of waking up one morning to find the mother absent, to be told that she has gone to the hospital to have a baby, and then to have her return with an infant who engrosses her time and attention, is the unhappy fate of many children whose parents either ignore their need for prepara-

tion and reassurance or else deny it because they cannot face the questions about sex and procreation involved. So many children suffer unnecessarily from the arrival of a younger brother or sister when that arrival could be the occasion for happy expectations and enjoyment! Here we have an excellent illustration of how children are sacrificed to religious and moral traditions that insist upon denying sex and hiding procreation as something shameful and obscene.

The symptoms of sibling rivalry, often aggravated by overt favoritism for the new baby and rejection of the older child, are many and various. The young child is faced with the necessity of accepting a place and a rôle for which he needs much affection and reassurance, which he may not receive at home or at school. Often this shock comes just as the child is striving to learn toilet habits, so that he is under a double load of anxiety which may lead to "slips" or persistent enuresis.

The frequency of rejected children—children not wanted or not acceptable as personalities or temperaments to the parents—is so great that special mention should be made of the need of such children for something to compensate for their unhappy fate. In this group must be numbered the children of oversolicitous mothers who are hiding their rejection of the child under an effusive care and atoning for their guilty feeling by "smothering" the child. Nursery schools have a great opportunity to meet the acute needs of these children.

The little child is frequently disturbed physiologically by emotional reactions such as anger, rage, and grief which clamor for expression or release in overt behavior. In a very real sense these physiological disturbances or upheavals seize control of the child and often impel him to act violently and destructively against things and people and even himself. One of the most important of life tasks for the young child is to learn how to manage these emotional reactions and thereby to free himself from this overwhelming experience. It is difficult for adults to conceive or to understand the panic that these emotional reactions may arouse in the child, who finds himself helplessly carried on a tide of feeling so strong that he cannot resist it unaided. If at the same time he meets

with a violent response from adults, who strike him or forcibly restrain him, the emotional disturbance may be aggravated cumulatively until terminated by exhaustion. Such an experience teaches the child nothing constructive or helpful, and it may make him so afraid of himself that he begins to be anxious about this behavior and less and less prepared to meet the next provocation. Although the adult may forcibly control the child at the moment, what the child needs is help in controlling the emotional disturbance himself, so that, instead of a persistent conflict within the child between himself and his emotions, he can bring these emotional reactions into the pattern of his own living. The situation is in many respects like that in the case of hunger and elimination, where physiological processes are initially dominant, but are gradually transformed into regulated functional activities over which the individual has, as we say, control, because those functional processes are subject to the culturally sanctioned times, places, and objects.

In other words, the emotional reactions of the child are normal physiological functions that call for regulation and patterning, so that the child may be freed from their urgency and disturbance. They are not, as our tradition teaches, moral or ethical problems, and when handled as such, they only increase the child's guilt and resentment and serve to fixate him at that infantile level, as in toilet training when it is made a moral issue. Anger and rage, like fear, have had a great biological value in the past, but in group living they may, as persistent infantile reactions, seriously interfere with the individual's capacity for peaceful, coöperative adult living, just as persistent incontinence of feces will restrict an individual's activities.

The child, then, needs help in bringing his emotional responsiveness under regulation. Some children are more prone to anger and rage, others to fear and pain, so that each child requires highly individualized help in meeting his peculiar personal reactions. Unfortunately we have little knowledge of how to provide this help in a constructive, rather than a repressive, manner, because we have treated the problems as moral issues, meeting them with threats, punishment, shame, and often equally violent emotional reactions. There

is need for much experimentation here in terms of physiological processes that need to be regulated and integrated into the child's total personality make-up through the help we can give him in his handling of these internal upheavals.

Perhaps the greatest need in these situations is for sympathetic reassurance that will allay the child's panic and so help him to meet the situation more effectively. If not helped early in life, the child may go forward with a capacity for violent reaction that his increasing size and strength make potentially dangerous, especially since he may, at the same time, be developing an increasing resentment toward others because of the way frustrations and deprivations are being inflicted upon him—a resentment that may later take the form of a persistent hostility and aggression, repeatedly reinforced by the revival of the infantile emotional reactions.

Fear and grief are also difficult reactions for the child to handle, but again we usually fail to provide really constructive help and only too often aggravate these feelings by our clumsy or careless attempts to dissipate them. Both fear and grief are physiological reactions that more or less paralyze or restrict activity, unless the fear activates flight. The child needs reassurance and reinforcement in meeting the strange, unknown, and apparently threatening experiences that confront him, and if we will accept the child's view that a situation is terrifying, even if we see that it is not, we can avoid the usual mistakes. Nothing is so helpful as learning some effective method of dealing with a fear-producing situation, since a learned motor response displaces the panicky fear of helplessness, as we see in the training of firemen, policemen, soldiers, and others. But many of the fears of children are not really physiological fears, but rather a disguise for other needs which the child cannot or does not reveal. It is the insecure, anxious child, the child who is not sure of himself or his place in the family or group, who appears fearful of situations that have no terrifying character, so that our earnest explanations and reassurances of safety are wholly irrelevant. Then, too, many children are reared under a constant threat of danger, the parents instilling fear before the situation arises in their efforts to protect the child, or the environment itself may be constantly terrifying. Again,

many children have suffered really shocking accidents or exposures to danger which have been indelibly impressed upon them, so that they are ever apprehensive of a repetition and live in dread. Children from such a background need a long experience of peace, of safety and security, to escape from the terror that dominates their lives. In some cases only repeated rehearsals of the shock will enable them to escape from their hysterical reactions.

In view of the frequency of fears in little children, fears that often persist throughout life and handicap the individual, we should recognize as of the utmost importance the child's need for help in dissipating them. But we must be alert to the difference between fears and the persistent anxieties that derive from ill treatment and neglect and that are exhibited as fears of specific situations only because the child must find occasional release.

Grief is another pervasive emotional response for which we have little adequate treatment. Children lose beloved parents, siblings, and nurses through death, divorce, or the inevitable changes in relationship, and something happens to them that we can only guess at, for the child has no comforting philosophy or belief to assuage the acute sense of loss. He can then only mourn, as we see a dog mourn a beloved master, inaccessible to our proffered sympathy or reassurance, because what is missed is that idiomatic, personal relationship that can rarely be regained with another. Children who are well loved can often find in the non-verbal response of those they love some comfort, but if they have lost some one of value in their lives, that loss may never be forgotten. The facing of death or deprivation, the acceptance of the inevitable, is one of the life tasks which mankind has never found a satisfactory method of meeting. To-day children are increasingly obliged to face another kind of loss that is more perplexing and difficult than death—the separation or divorce of their parents, which is so hard to explain to the child and almost impossible to render innocuous. In meeting this situation the child has needs that we can scarcely understand, but we must try to provide some kind of helpful assistance, because the experience is so devastating to the young child and so persistently disturbing throughout childhood and

especially adolescence. The conflict of parents, the frequent accusations and impugning of motives, all the bitterness and the competition for the child's favor, act as a psychological poison that, especially in the case of girls, may ruin the individual's capacity for adult mating, for one of the child's great needs is to build up images of the husband and wife, the father and mother, as guides to his or her own future rôle in marriage.

Another task of the child that is a source of anxiety, creating an acute need for reassurance and understanding help, is that of accepting his or her own sex and the many taboos that surround this subject. The traditional view of childhood is that children have no awareness of sex differences and no concern over their genitals, while the cumulative clinical evidence indicates that they are often greatly worried about sex differences and puzzled, if not greatly preoccupied, by their genitals. It is hard for a child to envisage the process of procreation, to accept his maleness or her femaleness, and to see any meaning or sense in the confusing "explanations" given, at the same time striving to understand the violent reactions of adults to exposure of the genitals, manipulation, and so forth.

Little children need constant reassurance and simplified enlightenment on questions of sex and procreation if they are to escape prolonged anxiety and possible lifelong unhappiness. In so far as nursery schools and other schools can provide children with an understanding and wholesome attitude here, we can see how the education of children may change our whole culture, for undoubtedly our culture is warped and distorted by our inherited traditions of uncleanliness, obscenity, and wickedness in regard to sex. We cannot expect to dispose of the child's curiosity and concern by purely biological explanations, since, as Otto Rank has pointed out, adults themselves are not satisfied with merely biological answers. Moreover, the exigent questions about sex, for the child and the adult, are not concerned with gestation, but with the uses of sex in living, in feeling, in intimacy and affection.

It is not too much to say that the ability of men and women to marry and to find happiness in marriage and family life is largely conditioned by their experience and acceptance of

their masculine or feminine rôles and sex differences during the pre-school years. If the boy is to grow up as a psychologically potent male, he must during the pre-school years develop his maleness and focus his future sex interests and needs in the genitals, since failure to do so at that time, as clinical evidence amply shows, will compromise his adolescence and prevent his achievement of a wholesome heterosexual adjustment toward women. Likewise it is clear that the little girl, during the pre-school years, must get a clear idea of her future feminine rôle, must accept her essential biological, physiological, and anatomic difference from the male and begin to look forward to her psychological differentiation as a female, with unique capacities for mating, procreation, lactation, and maternal and feminine rôles.

Children find these tasks, which should be simple, wholesome, and natural stages of pre-school development, matters of extraordinary difficulty and stress. Their parents, especially the mother, are so often suffering from anxiety, disgust, or fear about their own sex functions and needs that they cannot tolerate the child's natural curiosities and activities, nor can they permit the child's efforts to make these early life adjustments. Unfortunately many nursery-school teachers suffer from the same unfortunate conditioning, and so are unable to give the child the understanding and help he or she needs. It is not going too far to say that in some nursery schools the difference between boys and girls is ignored or rigidly suppressed, with serious consequences for the personality of the children.

As we gain more insight into the process of personality development and realize how crucial these pre-school sex interests and adjustments are for the subsequent adult life, we can and must work out nursery-school procedures designed to help the child to meet these tasks with courage and happiness, free from the distortions and anxieties that are now so prevalent, able and ready to give and to receive affection.

Another life task confronting the child is that of learning to recognize and observe the inviolabilities that every culture establishes with respect to objects, persons, places, and times. We are so accustomed to think of private property in things and animals, of the sanctity of the physical person of indi-

viduals, of the great number of special places and days consecrated to particular purposes which must not be profaned, that we fail to realize that private property and the sanctity of the person are not entities or mysterious powers, but learned ways of behaving toward things and persons, taught to children often with severe penalties for evasion or violation. These lessons as to the inviolability of things and persons are painfully learned by the young child as he begins to explore the world about him, seeking occasions for satisfying his needs and expressing his impulses, and being more or less forcibly restrained, rebuffed, and frustrated. He finds that everything and every person is protected by an invisible barrier of inviolability ("don't touch," "don't look," "don't eat," "don't go near," "don't handle") which he may not disregard except in duly sanctioned ways, such as buying and selling and making contracts or agreements. He must also learn to uphold the inviolability of his own person and property.

These lessons are not simple, since there are many fine distinctions to be made. What is freely accessible in the home is taboo outside; certain persons may be freely invaded, as in fighting with siblings, while others, such as strangers, are inviolable; certain persons are receptive to physical contact, such as parents or near relatives, while others not in the family group are untouchable; actions that may be performed in one place or at one time are forbidden in other places and at other times. Then, too, the child confronts the magical power of money, whereby small pieces of metal or paper render freely accessible what is otherwise inviolable.

These lessons are indeed formidable, and the young child struggling with the complicated customs of group life faces a heavy task for which he needs endless patience and sympathetic teaching. How often a little mistake over private property, which he is just beginning to understand, evokes sudden and immediate punishment, with accusations of "thief" and "liar" and other terrifying characterizations. When we realize that these early lessons in observing the inviolabilities are the most essential steps in preparation for group living, perhaps we shall devise more desirable and effective methods of teaching them, and shall remember to provide toleration

and reassurance for the bewildered child who is attempting to assimilate the cumulative customs of thousands of years. It is little wonder that the learning of these inviolabilities, involving as they do repeated frustrations and a form of negative conditioning that inhibits the response to biologically adequate stimuli of objects and persons, should so frequently impair the child's whole adult life, causing him to face every encounter and every negotiation with timidity or anxiety, or to be intensely preoccupied with getting the better of every one in all situations.

Besides learning to inhibit his responses to things and persons who are inviolable, the child must also learn to perform those acts which his parents insist upon as the required actions in various situations. These actions include the traditional manners and customs, the etiquette and the moral duties which the parents especially cherish and respect and which they are compelled to teach their children as the essentials of life. These lessons are difficult for the child because, like the inviolability of things and persons, the required conduct has no natural, biological relation to the situations in which it is demanded of the child. He must, therefore, be repeatedly shown what to do, and prompted and compelled to do it, with a greater or less amount of verbal and often physical punishment. The outcome of this training is the establishment of more or less automatic conduct, according to the required pattern, which is always a variation, peculiar to the family, of the general socially approved pattern.

As in the teaching of inviolabilities, parental instruction as to the performance of these required actions involves the exercise of authority, often by the father, who rarely has as close and affectionate a tie with the child as the mother and who, therefore, relies more upon coercion to exact obedience, while the mother relies upon the child's desire for her love and approval. Thus the child experiences authority and coercion for the first time, and only too often it is administered severely and arbitrarily, arousing in the child fear, resentment, and hostility toward the father.

These disturbing emotional reactions toward the parents, especially the father, are of crucial importance for the future of the child. As a member of a group, he has to learn to acknowledge and to accept authority, to recognize outside

himself a regulator, controller, and arbiter of conduct that is largely traditional, not reasonable or based upon anything but custom. He must learn to observe in his conduct the repressions and frustrations required by the inviolability of things and persons; and equally he must learn to perform various acts, from small courtesies to the greater, more important duties appropriate to his sex, status, class, position, and so on, accepting all these complicated and largely ritualized acts as necessary and desirable and as duly sanctioned by the law and the prescribed rules of social living. The development of such conduct involves the constant recognition and willing acceptance of the authority of the state, which, to be really effective, must function, not in physical coercion and police supervision, but within the individual himself. Authority, then, like private property, is merely a way of behaving toward individuals and situations; it is an attitude or effective reaction toward what is expected or demanded.

Now if the young child experiences authority for the first time as coercive, severe, and brutal, as something that arouses fear, anxiety, and resentment, his socialization will be compromised. He cannot calmly and gracefully accept that which is expected or demanded, performing acts or refraining from responses, but rather he will feel tension, will resent the parental authority, and will develop a persistent hostility toward the parents, especially the father, and all others who attempt to direct his conduct.

Instead, then, of accepting the inviolabilities or the required performances, the child who has been thus treated will fail to build those conduct patterns into an integrated whole, in which his behavior and his personality are at one. He may outwardly conform to what is demanded or prohibited, but only because of fear and anxiety. The learned conduct, essential to group life, is never assimilated or made wholly automatic, and so the child becomes preoccupied with the conflict between what he must do and not do and what he feels. Often he releases his feelings in misbehavior that is difficult to understand, for it gives the child nothing of value or advantage and usually is wholly incongruous with the situation. These aberrant actions are symptoms of conflict, modes of expressing resentment or hostility against authority that has made him fearful and unhappy.

With so many children exposed to this destructive experience of authority, destined by their persistent feelings of fear and resentment to unhappy adult lives, if not to more serious outcomes in mental disorders and criminality, the nursery schools are confronted by the urgent need of these children for help in accepting authority and in escaping these initial disturbances. Can we devise experiences in the nursery school that will enable the child to accept authority and to find freedom from the emotional conflicts and resentments that his previous experiences have engendered? The need is for ways of inculcating acceptance of authority without aggravating the already serious conflicts so many children have when they come to nursery schools; and this calls for reformulation of the problem, as discussed above, so that the authority will be transferred to the situation and divested of the personal element that evokes the resentment and conflict. Paradoxically, this depersonalization of authority depends upon a personal relation of the parent to the child wherein the exercise of authority is benevolent and helpful, not antagonistic and repressive.

This brings us to another life task of the child, who must create for himself, out of his experiences and the teaching he receives, an image of himself and of the kind of person he would like to be. This ideal of self will embody all the feelings of inadequacy and guilt that the child has experienced and must somehow express. Such feelings may lead to aspirations for constructive achievement, to altruistic, helpful conduct, and to other forms of expiation and atonement which, if not exaggerated into a neurotic drive for perfection, make the individual personality into a friendly, coöperative adult. Or they may lead to hostility and aggression, which take the form of intense competitive striving or coercive conduct; to delinquency, so that the individual may obtain punishment; or to mental disorders, in which the individual punishes himself. All these adjustment patterns are exhibited in childhood, when the child already has adopted his "style of life," and if we had enough insight and understanding, these adjustments might be treated in the nursery-school group in such a way as to mitigate, if not actually to revise, these personality trends. No one can prescribe a general method or procedure for all children, but undoubtedly the largest single element in

the situation is the kind and extent of affectionate personal interest shown by an adult toward the child, who thereby may find much needed help toward a constructive, not a self-defeating, ideal of self. The process of identification, wherein the child strives to emulate an admired and loved adult, makes the teacher-child relationship of crucial importance. Lack of sympathetic understanding, of tenderness and patient toleration, may turn the child toward hostility and aggression, from which he can be reclaimed only by long and difficult therapy later, if at all.

One of the most important problems facing students of personality to-day is this question whether hostility and aggression are inborn characteristics of all individuals or whether they are the reactions of individuals who, as infants and pre-school children, were deprived of needed love and affection and security and so were driven by the unrelieved pressure for socialization to hostile, aggressive, destructive conduct. This question is of the utmost importance socially and educationally, since the answer involves the future of our society and of the civilized world. If man is innately hostile and aggressive, prone to destructive antagonisms and rivalries, then the prospects for a better, more humanly desirable society are not very bright. If human nature, as theological tradition and many of our contemporary students of personality tell us, is born wicked, sinful, and hostile and must be forced to be social, coöperative, and altruistic, the task of education is essentially a coercive one, that of curbing the hostility, of teaching individuals to "handle their aggressiveness." If, on the other hand, human nature is essentially plastic, subject to educational direction toward friendliness, coöperativeness, gentleness, and genuine group or social activity, then the task of education is to prevent the early distortions and unnecessary deprivations that arouse resentment and aggressiveness, by providing as much affectionate reassurance and toleration of individual, temperamental differences as possible for the children who have been ill treated or neglected by their parents. Here pre-school education has an immense opportunity and responsibility for the future course of our culture.

But here we must ask whether we know enough now to meet

this issue of resentment and aggressiveness wisely. The policy of restraint and repression in many schools may prevent fighting and disorder for the moment, but it does nothing to release the child from the inner tensions and frustrations of which his aggressions are but symptoms. Perhaps we have to face a mixed answer to the earlier question and realize that tensions and resentment are probably present in all children in the early years, as a necessary consequence of the process of deprivations and coercions they undergo during socialization. Whether these tensions will become persistent, lifelong hostile attitudes toward the world, or be replaced by friendly, coöperative attitudes, may be the critical issue of pre-school education. No permanent good is achieved by a repressive policy, nor is any constructive end attained by permitting the children to fight it out, with the risk of damage to all concerned. What is needed is an imaginative, insightful handling of conflicts and aggressions on an experimental basis, addressed to the underlying anxiety, guilt, and frustrations and the need for reassurance and security. There is also need for methods of handling situations in such a way that the initial hostility or aggression of the child may be rendered unnecessary by opportunities for friendly, helpful responses. Many children do not know how to act coöperately and need the skillful guidance of an adult to encourage them in friendly conduct and sympathetic actions. It must be realized that repeated rebuffs and frustrations may transform love into hatred and aggression, so that the child can only attack what he has most desired.

This brings us to the exigent question of freedom and self-expression, over which there has been so much controversy and often hasty action. It may help us to obtain some perspective on this question if we will remember again that the child faces a series of unavoidable life tasks, including the persistent problem of how to get along in an organized group life. To the young child the world around him is indeed precarious and ambiguous. He faces a natural world often dangerous and always puzzling even to adults; his own organism, with its many functions and needs which must conform to parental and social patterning; obscure, often unconscious, impulses that impel him to actions that frequently he cannot

understand, and that others usually resent, rebuke, and often retaliate for; a social or cultural world organized into patterns of behavior and regulated by symbols, such as language, that are subtly differentiated and variable; a constellation of human relationships, in the immediate family, the wider kinship group, the neighborhood, and the school, among which he must find personality fulfillment and security despite the capricious and disparate character of all these impinging personalities; and finally an immense body of tradition and folklore, knowledge, skills, and play.

Faced with such a welter of confusing, conflicting adjustments, the young child desperately needs the security of stable, persistently uniform situations, of dependable human relations, and of endless patience and tolerance. The frequent cry against any repression of the child involves a confusion that is often tragic for the child. Every culture involves deprivations and repression, the patterning and regulation of physiological functions and human behavior, which, if wisely handled, are only redirections and modulations of impulses. The young child especially needs a wisely administered regulation or direction because he cannot sustain the immense burden of making individual decisions on all the aspects of life and of learning unaided to manage his impulses. Few adults can do this, as we see in the overwhelming need for guidance, for precepts, for legal, ethical, and religious direction. Moreover, the regularization of hunger and elimination and the respecting of the inviolabilities leaves the individual free for other activities and interests that would not be possible if he were continually driven by hunger, beset by impulses to elimination, and at the mercy of every provocative personal contact or sexual stimulus. These learned patterns and repressions are the chief factors in man's ability to go beyond a purely organic existence. It is not the ordering of life that damages the child, but the distortion, the fears, anxieties, and permanent frustrations and inhibitions that parental and educational practices unnecessarily inflict upon the child in the process of establishing these socially and individually necessary repressions.

It is also the confusion and anxiety and insecurity of capricious, vacillating teaching that damages the personality in

search of something stable and constant to build upon. Children love order, regularity, repetition of the same pattern endlessly, and they need consistent adult guidance and help in learning these patterns of what is essential to their adult life and social living. But they do not need, nor can they safely endure, the fears, the anxieties, the feelings of inadequacy and of guilt that so many parents and teachers instill during this socialization process. Indeed fear seems to be the chief psychological instrument in early child-rearing—either the arousal of fears by cruel and coercive treatment or the inculcation of fears of experience, of people, of living, which cripple the child for life. Fear, and the resentment or hostility it often generates, are indeed the major emotional drives in our social life and give rise to much unsocial and antisocial behavior. What the child needs, but seldom receives, is a clear-cut definition of the situation and of the conduct appropriate therein, so that he can and will learn what conduct is permitted and what is not permitted without the emotional disturbances he now experiences during these lessons. Practically, this means that the teaching by parents and teachers should stress the desirability or undesirability of the action without imputing blame to the child, so that instead of the usual admonishment, "You are a bad, naughty boy!" the statement should be, "That action is not desirable or not kind, not generous or not permissible, and I don't like it." The important difference is in the personal imputation of guilt and the emotional disturbance it creates in the child.

As many writers have pointed out, the child accepts socialization and the inevitable frustrations and repressions involved largely because he wants love and security from the parent and teacher. The long-popular method of asking the child to do this or that "if you love me," is especially damaging because it fails to create a recognition of impersonal authority in situations. The love for parents should never be exploited to control the child whose anxiety lest he lose that love is already great. The traditional manner of teaching, by calling the child bad or wicked when it is the behavior that should be defined as undesirable, makes the child fearful, guilty, and unhappy, and, if continued, may establish a persistent feeling of guilt and inadequacy and of being rejected.

To assuage that feeling of guilt and to overcome the sense of inadequacy and rejection, the child may commit more anti-social or forbidden acts to get the punishment he needs for his guilty feelings or to prove that he is not worthless. As Dr. William Healy and Dr. Augusta Bronner have recently shown in their study, *New Light on Delinquency,* the delinquent generally has had an unhappy childhood, characterized by feelings of rejection, inadequacy, and guilt, and by lack of affection.

This point about the necessity of socialization for the child without undue emotional stress and strain during the process is being emphasized here because it has such great consequences for our social life. If we could persuade parents and teachers to avoid characterizing the child as bad or naughty, while defining the behavior, and then give the child ample reassurance when receiving such lessons, undoubtedly we could make an immense contribution to the reduction of delinquency, criminality, and other non-criminal, but socially destructive conduct on the part of those who spend their adult lives proving by the acquisition of property, prestige, and power that they are not as guilty or as worthless as they were repeatedly told in childhood.

This question of socialization of the child without distortion and emotional disturbances must be seen in the light of the great individual differences among children in intelligence, temperament, rate of maturation, and need of reassurance, so that each child may be treated individually. The professional urge to standardize, to routinize, to substitute academic training for sympathetic interest and insights into children and to look for uniformities and generalizations that will save thinking, all must be critically reëxamined by nursery-school educators who are aware of these large social responsibilities. Especially is there a need for questioning the well-established principle that nursery-school teachers should be impersonal and should repress all affective responses to and from children. This principle came into vogue in the 1920's when behavioristic theories of child-rearing were dominant. The ideal of education was seen as that of almost complete emotional anesthesia and continually rational conduct, which is the ideal of the neurotic who is afraid of life and is seeking to

suppress all feelings, of which he is fearful. As we realize how much the child is in need—as indeed all adults are also—of warm personal, human relations, of affectionate interest and real concern, and of opportunities to give and receive affection and to *feel,* we must challenge this old principle as directly contrary to the deepest need of the child and as destructive of human values, which can be preserved only by sensitivity and feeling tones toward people and situations.

Here it is necessary to ask why are we so afraid to recognize that the child needs mothering, not only at home, but in the nursery school, and that nursery-school teachers, by the very nature of their work, must be mother surrogates, ready and capable of giving affection and tenderness and warm emotional response to the children and of accepting them from the children. Is it because mothering does not seem scientific that we have tried to exclude it from the nursery schools or because—and I say this in no critical spirit, but as a statement based upon the actual situation—so many of those in nursery-school education are unmarried and childless and have unconsciously projected their own personal life adjustment into the training of nursery-school teachers? When we reflect upon the number of children in all classes of society who are raised by fear, terror, punishment, and other sadistic methods, with little or no experience of love and affection, we may well ask whether mothering (not smothering) may not be the most important service the nursery school can render to little children. Mothering does not mean babying or pampering, but rather giving a feeling of being liked and wanted, of belonging to some one who cares, and of being guided in the conduct of life with benevolent interest and confidence.

Dr. David Levy, a year or so ago, told this story at a meeting of the American Orthopsychiatric Association. He said that the social workers in the Bureau of Child Guidance were having unusually successful results with problem children, just because they were being maternal to these boys and girls so frequently denied real mothering. But they gave up this procedure because, said he, it did not seem scientific and was so hard to record! Perhaps if the nursery-school teacher were to consider her function as not only educational, but clinical, it might be easier to accept what the psychotherapeutic clinician accepts—namely, the rôle of parent surrogate,

who gives the child individual, personal interest and attention and tries to help that child work out a design for living by providing direction and deprivation, but always with interest and helpful concern.

Finally, we must look at the question of socialization in the light of the cultural changes through which we are now living, which are bringing about the destruction of so many of our traditional ideas, beliefs, and older certainties. The men and women of to-morrow will have to live in a shifting, uncertain world, of rapidly changing ideas and conceptions, with few or no absolutes or certainties. What is to guide their lives, to help them find fulfillment and a design for living sanely, wholesomely, and coöperatively? Probably no previous generation has had to face such acute personal problems without help from religion, custom, and tradition. Either they will demand an authoritarian state because they cannot endure uncertainty or tolerate the destructive hostility and aggressions of unhappy individuals, or they will learn to seek in constructive work and recreative play, in the warm human relations of marriage, parenthood, and the family, a way of life that will permit realization of the enduring human values.

The nursery school, in close and coöperative relationship with the home and parents, is the primary agency for mental hygiene. The opportunity in pre-school education to build wholesome, sane, coöperative, and mature personalities, and to determine the future of our culture, is unlimited. The discharge of that responsibility lies in helping the young child to meet the persistent life tasks and to fulfill his insistent needs. But the nursery school cannot do this alone. It must have collaboration from the kindergarten and the grade schools, and it must find some way of coöperating with the home and the family, despite the frequent blindness and resistance of the parents. If nursery-school teachers were to realize that they are like parents, with their personal peculiarities, their emotional resistance and susceptibilities, their ignorance and rigid convictions—which may be just as undesirable for the child as the home practices they deprecate—perhaps such a realization would make them more tolerant and more willing to seek a basis of collaboration in meeting the fundamental needs of the child. The family can and does

provide the child with a place, a status, with "belongingness" and often much needed love and affection. Can the nursery school organize its procedures and prepare its teachers to meet these same needs and also those other educational needs which the family has difficulty in supplying?

The fundamental needs of the child are in truth the fundamental needs of society.

EDUCATIONAL FUNCTIONS OF THE PRESENT-DAY MENTAL HOSPITAL *

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IT is our objective in this paper to point out some of the relationships between the mental hospital and the community that it seems desirable to cultivate. This applies particularly to educational relationships.

We realize that there are still in this country some institutions for the care of the mentally ill which, because of inadequate staff and equipment, cannot properly be called hospitals. Fortunately these are few in number and are becoming fewer every year. This paper is not addressed to such institutions.

You are quite familiar with the changes in attitude toward the care of mental patients and the function of institutions for the mentally ill that have occurred in the past two hundred years. Until 1792 very little consideration was given to the treatment of the patient. The main purpose for which institutions existed was to protect the community. In other words, their function was principally custodial, and was concerned with the segregation of patients rather than with their treatment. With the advent of Pinel in France and Tuke in England in the 1790's, however, the attitude changed. Pinel created a sensation by striking off the chains from more than fifty patients in the course of a week. It has been proved that Pinel's philosophy of management was good. His work was subsequently carried on and elaborated by Esquirol. About the same time in England, William Tuke and Lindley Murray, with the help of the Quakers, succeeded in building

* Read at the Ninety-third Annual Meeting of the American Psychiatric Association, Pittsburgh, Pennsylvania, May 13, 1937.

and opening the York Retreat. With this event the modern era, with respect to the treatment of patients, began in England. The influence of the York Retreat in handling patients without mechanical restraint gradually spread, and, as we know, has now permeated most of the English-speaking world.

During the past century there have been numerous advances in the treatment of the mentally ill. Refinements in treatment methods have continued to develop. The philosophy of the institution, however, did not change a great deal until approximately thirty years ago when the mental-hygiene movement began in this country. This movement is so recent that it seems unnecessary to review it here. It has resulted in a change in the attitude of the mental hospital toward the question of mental disorder and the legitimate activities of the hospital. These activities are no longer confined to the four walls of the hospital, but extend in many directions in the community.

A great deal of effort has been devoted to enlightening the public as to the nature and manifestations of mental diseases, and it is this educational function of the present-day mental hospital that we should like to review briefly here.

One of the first educational responsibilities is the training of the hospital's personnel. This has a double objective. The primary aim is to supply the hospital with an adequately and scientifically trained staff, as it is obvious that the more adequately trained the personnel, the more efficient will be the care given the patient. No surgeon would think of using a dull scalpel in the performance of his operation; no internist would think of using an inactive preparation of digitalis; no hospital administrator should think of using as his therapeutic instruments a poorly trained medical and nursing staff.

The second objective is to train physicians and nurses who are going out into the community. If they are well versed in the principles of mental disease and what we know about its manifestations and prevention, they can perform a very valuable public service and contribute greatly as missionaries by using their knowledge in practice and conveying it to the general public.

In fostering this type of training, it seems desirable that the mental hospital should encourage young doctors and

nurses who are going into private practice in the community to spend some time in a mental hospital. In the case of physicians, a period of interneship should be encouraged, and in the case of nurses, an affiliation in connection with their ordinary training should be offered.

In addition to doctors and nurses, there are also certain hospitals which extend affiliate training to other professional groups. Several hospitals in this country take in groups of theological students and give them a period of residence in the hospital. There has been a suggestion that certain of the legal groups spend some time in a mental hospital during their professional training. We have been unable to find any hospital in which this is being done at the present time, but it would have certain advantages.

Greater understanding of the difficulties of the mental hospital, with regard to housing, equipment, staff, and training, may enable us eventually to do something about this ever-increasing problem.

It is common practice in a great many states to operate mental-hygiene clinics in connection with the hospital. These, too, serve a double purpose; not only do they reach incipient cases of mental illness and maladjustment, but they also serve as a means of disseminating information about the problem of mental disease. These clinics are sometimes set up separately and apart from the hospital, but in many instances they are a part of the hospital service. When no other provision is made for the operation of such clinics, this is probably the best method of dealing with maladjustment in the community. In addition, it serves to keep the hospital in touch with community problems and the community in touch with the hospital.

A question arises in connection with these clinics, and, as a matter of fact, with any clinic operated by public funds, and that is the question of the attitude of the medical profession at large to the clinic. There is a great deal of resentment in the profession against the inroads of anything that resembles state medicine. Many consider these clinic activities as a wedge that is being driven in the direction of state medicine. In practice, it is questionable whether this is the case or not, because by far the greater number of cases that

appear in a mental-hygiene clinic are not such as could be handled successfully by the average practitioner. The general practitioner who is not specially qualified in mental medicine is not familiar with the problems involved, nor has he the follow-up facilities that these cases require. The mental-hygiene clinic, using the services of a psychologist and a social worker as aids, is able to render more effective service than would be afforded by the average practitioner.

We do feel, however, that these clinics should not receive patients for advice, examination, or treatment unless the patient presents a letter from his own family doctor or from some local physician. In this way a great many difficulties that have arisen in the past might be avoided. This is not a minor point, but a major one, and sometimes it may spell either success or failure for the clinic. One of the prime requisites of such a clinic is that it shall be acceptable to our brother physicians.

The question of the patient's relatives is an important one for the hospital. It is said, and very aptly, that at times one may not be able to do a great deal for the patient, but that a great deal may be done for the relatives. It is essential in the treatment of the patient that there should be an harmonious relationship between the hospital and the relatives. We are familiar with the disturbing effect on the patient of a visit from a relative who is upset and disgruntled. It is the hospital's duty to educate the relatives with respect to the patient and his illness and the problems of the hospital. An excellent opportunity exists for informing relatives about the needs of the hospital. Many difficulties arise with relatives on the basis of inadequate housing of patients and inadequate staff, and consequently many openings present themselves for missionary efforts in this direction. It is a good plan at times to allow relatives to attend patients' entertainments and to offer them opportunities to acquaint themselves with the general hospital routine.

There is another point in connection with relatives and friends that is of particular importance. That is the question of visiting days. It may be very desirable that friends and relatives should be able to visit at any reasonable time, but other factors must be taken into consideration, such as the

amount of time that it is necessary for the medical staff to devote to relatives and friends, and also the fact that visits break into the patient's routine of treatment. It must be remembered that for every hour devoted to relatives, an hour is taken away from the time that it is possible to devote to patients. As a general principle it is desirable that visiting hours should be confined to certain days in the week. The ideal method of dealing with this problem would be to assign one or two physicians to do nothing but keep in contact with the progress and condition of the patients and be responsible for the interviews with relatives. One realizes, of course, that in some instances patients react very badly to visits; in such cases the frequency of the visits should be reduced to a minimum.

Mental hospitals are in a strategic position so far as psychological and clinical material is concerned, and a great service may be rendered by allowing the facilities of the hospital to be used educationally by other professional groups. The use of the hospital by students in psychology and the social sciences is profitable and of value both to the hospital and to the student. It would seem very desirable that, when possible, close association with colleges and universities should be established. There is no question that the facilities of the hospital should be extended to medical schools and medical students when this is possible. In hospitals where active educational procedures are going on, one finds among the staff a more lively interest in clinical work and a better appreciation of what other professional groups have to offer in the field of mental disorder. The hospital staff becomes more alert and more inquiring. On the other hand, outside professional groups who come to the hospital for courses become more familiar with the problem of mental disorder, are stimulated to inquire further about the subject, and exert a favorable influence in the community afterward.

It is worth emphasizing that the community should be familiar with the problems of the mental hospital because the hospital belongs to the community and is a direct responsibility of the community. It is possible, as a last resort, that patients suffering from a physical illness may be cared for at home. Operations have been performed successfully on

kitchen tables. The individual suffering from a mental disorder of any magnitude constitutes a different problem. For many reasons, he must be cared for, at least in acute phases, in an institution; and the community must provide the institution.

At present a great many mental hospitals are not adequately staffed. They have difficulty in getting appropriations to provide a sufficient number of medical and nursing staff to meet the minimum requirements of the American Psychiatric Association. It is reasonable to expect that the more adequate the staff, the better trained it is, and the better the equipment of the hospital, the more effective the treatment of the patient. Experience has shown that adequate staff and equipment reduce the time that it is necessary for the patient to spend in the hospital. The shorter the stay of patients, the less money the community has to spend. Unless the public are brought to realize this, it is going to continue to be very difficult to get enough money to staff and equip hospitals adequately. If people can be educated in these matters and shown that they will save money in the long run by providing adequate facilities, then it is reasonable to expect that something will be done. We believe that the public shows a sympathetic response when it becomes familiar with the difficulties and requirements of the hospital. Few people, when they understand the problem, oppose the measures required to provide adequate staff and equipment.

We believe that a community that is familiar with the mental hospital will not tolerate political interference in the management of the hospital. One does not have to dilate on the evils of political machinations in the field of mental health. When politics creeps in, efficiency does not creep out, it gallops out.

Arising out of the community-hospital relationships mentioned above is another important question. Officials vested with the responsibility of providing care for the mentally ill should be in a position to advise the public as to the increasing magnitude of the problem over a period of years and be prepared to state, with reasonable accuracy, what the expected increase in patients will be from year to year. These figures should be available at least five years in advance, so that an

adequate building program can be projected. A few states have done this successfully for a number of years. The figures can easily be arrived at on the basis of the patient and population increase that has occurred in the past. When definite figures are available, it is much easier to secure the necessary financial provisions. The community should be made conversant with these requirements and with the greatly impaired efficiency that results from overcrowding and inadequate housing.

It seems to us desirable that the public should not be called upon to face increasing expenditures over a period of years if anything can be done to reduce the incidence of mental disease and its more effective treatment. Nothing will be accomplished in this direction unless investigative campaigns are initiated. Nothing will be accomplished by sitting down and waiting for something to happen. Active work is required If progress is to be made in the investigation of mental disease and in treatment, funds should be appropriated for this purpose. It is not unreasonable to ask that out of every dollar necessary for new buildings, one cent should be appropriated to stimulate investigation and research. It is encouraging that some hospital systems at the present time are doing very laudable work, but the surface has only been scratched as yet. The field of mental disorder is a vast one and serious in its economic consequences. Increasing knowledge, attended by research, will repay an hundredfold every dollar that is spent on it.

The hospital has a definite obligation to the patient and the community to keep abreast of new developments in psychiatry, particularly in the field of treatment. Any treatment that may shorten the stay of the patient in the hospital or that offers any hope of benefit, either immediate or remote, should be investigated. It may not be feasible sometimes actually to try out the treatment, but it should be feasible at all times to keep in touch with people who are trying it out. Hospitals may legitimately be criticized by relatives and by the public when they lag behind in utilizing knowledge that is at hand. The prime requisite in keeping abreast of current knowledge is, of course, an adequate library. The importance of this, particularly in hospitals situated in outlying territory,

cannot be overemphasized. When the medical staff, by virtue of geographical remoteness, are deprived of professional contacts, the library is the only resource they have to fall back on to avoid stagnation.

In conclusion, a community-hospital relationship has been developing in this country in the past few years that merits a few comments. We refer to the extramural care of patients, a boarding-out system whereby patients can be looked after in the community rather than in a hospital. A discussion of its pros and cons does not fall within the scope of this paper. The educational aspects of such a scheme, however, are worth considering. To provide suitable boarding-out homes, it is necessary to make a thorough survey of the facilities existing in the community. This, of course, brings a representative of the hospital into intimate contact with a great many homes and thus tends to familiarize the public with the requirements for the proper care of mental patients. Frequent visits by social-service workers and hospital physicians following the progress of boarded-out patients also afford an opportunity for contributing to the education of the community. The mere fact that patients are boarded out in certain homes becomes a topic of conversation, particularly in rural areas, and often results in bringing the hospital into touch with sections of the public with whom it formerly had no contact. There must of necessity develop as a result a closer association between the hospital and the public. Leaving aside other considerations such as cost, therapeutic effectiveness, and so forth, it would seem that such a scheme would have many advantages and might develop into a valuable technique in furthering the educational policies of the mental hospital.

Thus we realize that in the past quarter of a century much has been done to give the public a better understanding of mental disease and a better knowledge of the mental hospital. Much remains to be done in order to bring about a situation in which the community will know as much about mental illness as it now knows about medical, surgical, and pediatric illness. When in need of psychiatric treatment, people should be as ready to enter the mental hospital as they are to enter a general hospital. The tools for bringing about this understanding are now fairly well understood; the techniques have

been frequently and successfully utilized. It remains only for those who are entrusted with this responsibility to use the tools, to make further demonstration of the techniques, and thus to advance public understanding of the place of the mental hospital. Its usefulness in the prevention of mental disease and the treatment and cure of mental patients will then steadily progress. We cannot believe that in meeting this responsibility the psychiatrist will be found wanting.

THE COLLEGE STUDENT AND FEELINGS OF INFERIORITY

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THE twentieth century has been called the age of Freud and the intelligence test.[1] The contention of Binkley that each age has its own peculiar conception of human nature which determines its estimate of values seems to be borne out by a study recently made of 2,342 students of the University of Minnesota.[2] Of these, 67 per cent were conscious of defects in their personalities which were considered sufficiently serious to be an obstacle to their happiness and satisfaction in life. Thirty-eight and five-tenths per cent expressed these limitations in terms of feelings of inferiority, 25 per cent defined their difficulties in terms of adverse personality traits, and 3.8 per cent ascribed their feelings to physical and mental defects. Only 10 per cent felt that they had no limitations within their own personalities which would jeopardize their future adjustments.

A recognition of personalty difficulties does not necessarily mean a lack of adjustment. The individual who recognizes his personality limitations and acceptably accommodates to them may in fact be a very well-adjusted person socially. The study on which this article was based, however, asked the student to list factors that he considered obstacles. It may be assumed, therefore, that testimony as to the existence of such obstacles is an indication that they constituted a problem in adjustment to the student.

[1] Quoted in *College Standards and Human Values*, by H. Austin Aikins. MENTAL HYGIENE, Vol. 20, pp. 366–83, July, 1936.

[2] *A Study of Student Aims, Limitations, and Working Philosophies*, by Anne F. Fenlason. Part III, *Study of Student Social Activities*. Minneapolis: University of Minnesota, 1936.

There have been two approaches to the study of the inferiority complex, with little synthesis between the two. One approach is concerned with theories of inferiority based on clinical cases; the other approach is through measurement of inferiority traits in large groups of a supposedly normal population. One of the most significant contributions in this approach was that of Heidbreder, who devised a self-rating scale based on the concepts of Adler.[1] Of the newer research projects along this line, an important one is that of Rundquist and Sletto, who included a measurement of inferiority attitudes as part of a general adjustment scale.[2]

Recognizing that social adjustment is an important phase of education, the study at the University of Minnesota was undertaken in 1934 to determine the extent and character of the students' social activities. One part of this problem was the student's attitude toward his own adjustment. An effort to ascertain this was made by asking the three following questions:

1. What factor do you consider most important to your happiness and satisfaction in life? (Such as professional success, financial success, social prestige, friendship, marriage, approval of a certain individual or group, breadth of interests, pleasant recreation, material possessions.)
2. What do you consider the chief obstacles that prevent your attaining greater happiness and satisfaction?
   a. In your own personality
   b. In external conditions
3. Whether or not you have consciously formulated it, you must have developed some sort of philosophy which influences your actions. Describe it as clearly as possible.

The sheet was spaced to leave room for expanded replies under each question. The students were instructed to use the reverse side of the sheet if more space were needed. The replies were anonymous, which may account for the apparent frankness and lack of inhibitions in discussing questions of so personal a character.

The questionnaire on social activities was put in the post-office box of every student in the university who had been in school in the fall quarter of 1933 and had returned for the

[1] See "Introversion and Extroversion in Men and Women," by Edna Heidbreder. *Journal of Abnormal and Social Psychology*, Vol. 22, pp. 52–61, April-June, 1927.

[2] See *Personality in the Depression*, by E. A. Rundquist and R. F. Sletto. Minneapolis: University of Minnesota Press, 1936.

winter quarter. Each questionnaire was accompanied by a letter from the president of the university explaining the purpose of the study and asking for the coöperation of the students in it. Of the 10,279 students enrolled, 9,682 received questionnaires; 2,342, or 24.2 per cent, returned the insert sheet.

THE RELIABILITY OF RETURNS ON THE INSERT SHEET AS DETERMINED BY COMPARISON WITH PROPORTIONATE STUDENT ENROLLMENT FOR THE YEAR 1933–1934

Classification	*Percentages of student body in different groups*	*Percentages returning insert sheet from different groups*
By sex:		
Men	60.9	62.0
Women	39.1	38.0
By class:		
Freshman	27.4	25.7
Sophomore	27.2	26.7
Junior	15.3	18.4
Senior	13.9	17.7
Graduate	11.5	7.6
Unclassed	4.7	4.0
By college:		
Science, literature, and the arts	31.6	38.3
Professional	30.3	23.7
Education	11.7	14.9
Graduate	9.4	6.8
General	6.6	4.7
Agriculture	6.6	7.8
Miscellaneous	3.7	3.8

The accompanying table shows that the returns on the insert sheet were representative of the university population. The percentages of men and women answering it paralleled the percentages of the sexes in the university enrollment. Slight, but significant, variations are found in the junior and senior classes, where the percentages answering are slightly higher than the percentages of the university population represented by these classes.

We have excluded from this paper the students whose answers were classified under "adverse personality traits," "physical and mental defects," and "emotional disorders," and have confined it to those 902 students—501 men and 401 women—who expressed their sense of personal inadequacy in

terms of feelings of inferiority. The terminology embraced such phrases as:

"inferiority"	"too backward"
"inferiority with compensation"	"shy"
"shyness"	"bashful"
"self-conscious"	"timid"
"feel uncertain and inferior"	"lack of confidence"
"lack of forcefulness"	"fear of crowds"
"few friends"	"fear of being made a fool of"
"inability to make friends"	"inability to talk"
"lack of social grace"	"lack of poise"
"lack of refinement"	"lack of cultural education"
"awkward"	"can't dance"
"embarrassment"	"feeling of superiority"
"self-depreciation"	"overmodest"
"aloofness"	"fear of others' opinion"
"difficult to meet others"	"introversion"
"can't project presonality"	"lack of men friends"

It was interesting to note that women tended to express their lack of adjustment in feelings of inferiority to a much greater degree than did men; 45.1 per cent of the women as compared with 34.5 per cent of the men expressed themselves as feeling inferior. In the graduate school, however, we found that the percentage of men expressing feelings of inferiority was much higher than the percentage of women; 42.4 per cent of the women in that school admitted to feelings of inferiority as compared to 55.4 per cent of the men. This may imply that the man in the graduate school is predominately an introverted person. It may mean that he is old enough to have assumed family responsibilities which the small graduate stipend makes it difficult for him to meet. It may mean that he is facing insecurity in the immediate future because of the competition in the market for postgraduates, with the supply still exceeding the demand. Whatever the meaning, the fact remains that the highest percentage of feelings of inferiority was found among the graduate male students.

Graduate students of each sex had a significantly higher percentage of feelings of inferiority than the combined sexes of the freshman, sophomore, and senior classes, as well as the unclassed and unclassified students. Just why this ratio of significant differences should not hold true for the junior group is a matter for conjecture. It may be that the junior year is the one when the student is exposed to courses in

abnormal psychology and mental hygiene and becomes conscious of mental and emotional difficulties expressed in terms of inferiority to a greater degree than at any other time during his college course.

While we have not the data for analyzing the causes of inferiority of the college student, we found in many of the answers a possible and partial exposition of mechanisms. The unconscious defense against a sense of inferiority was revealed by the woman graduate student who admitted to "a frigid reserve that usually makes people think I am haughty. I have a natural shyness and embarrassment and not enough self-confidence and poise. In the case of men not enough of the Shakespearian 'up and coming attitude.' I am probably not predacious enough." She bolstered her self-respect by feeling that "men do not appreciate an intelligent girl":

> "They take it as a personal affront if a girl has a few ideas to rub together. I have not been able to contact male friends who are interested in music and literature as I am. They think a well-developed vocabulary a heinous crime against society."

A feeling of inferiority for which compensation had been sought in another form of behavior was indicated in the case of the young woman who tried unsuccessfully to cover up her feelings of inadequacy by substituting adverse personality traits. She wrote:

> "I am too blunt and unpleasant to people. I usually insult them by telling them just what I think. They are usually offended to hear, for the first time, what has been an obvious, but concealed truth to others."

She revealed the key to her difficulty when she ended, "I am timid and shy." Her sense of inferiority as a salient characteristic seemed to have been enhanced by material obstacles.

> "I have no political pull to aid me in getting a job. My appearance isn't any too pleasing. I live in a level which does not throw me among influential people who might aid me in my schooling. I must depend on superior skill to outweigh my other defects. I am unable to command respect any other way."

Many students blamed their sense of inferiority on the lack of opportunity or limitations in their environment. The case of the student who told of "an inability to enter into campus activities unless urged by some one else" is a case in point.

In answering the question on external obstacles, she complained of:

1. No opportunity to meet people other than on a professional basis
2. Lack of money
3. Lack of proper clothing
4. Lack of experience in social situations.

Still another graduate student who listed an "inferiority complex" as her chief personality difficulty interpreted its origin in terms of environmental obstacles. She explained:

> "At the time I entered college, our family suffered such severe financial reverses that I found it necessary to do housework for my room and board, which did not raise my ego at all. My clothes were made by a small-town dressmaker and they were all 'wrong,' so although some small-town friends were kind enough to propose me for rushing, I always made a bad appearance because I was ill at ease on account of my appearance. Also because of the financial reverses I never felt that I could invite friends to my house, and since I've been in school I've never had a suitable place in which to entertain friends at ease. Even when I was teaching, there were debts incurred in college or in the support of younger brothers, as well as occasional aid to parents, so there never has been the financial security which gives poise. At present I'm out of a job and shabby."

The scarring effect on the personality of financial insecurity is well described here. Unfortunately, this is not an isolated case, but one whose essential features of lack of money, no prospect of a job, shabby clothes, and no place to entertain, with resultant feelings of personal inadequacy, were repeated over and over again.

The portrait of the graduate student just cited was copied in outline by the freshman who said that she flushed easily, was self-conscious, and had a father who "does not like people to come to the house when business isn't good, and it hasn't been for some time." She felt that their home was not as good as the homes of her friends nor as new as she would like to have it. She also felt the financial pressure in the home.

The desire for social contacts was most often indicated by the individual who acknowledged feelings of inferiority. Classroom contacts apparently are of little help in this situation. A junior woman student in the school of business sadly recorded: "Meeting people in classrooms is not meeting them socially." She complained:

> "Nobody cares two whoops what happens to me or what I do, so I let them alone and get along as best as I can by myself. After all

I can entertain myself fairly well, but I really would like more contacts. Seeing that I haven't the forwardness necessary to make them, let things take their course."

The relation between an inferiority complex and a program of student social activities at the university was implied in the reply of the student who said that she was "backward about making friends in new groups unless responsible for others." She had "an inability to talk freely to some groups due to a limited vocabulary and experiences limited to a small town." Although the statement has no basis in fact, she said that there is "no effort made in large groups like the university to make social life more pleasant for the average person." This attitude, which is by no means unique, indicates the difficulty in making available to the student most in need of them the social opportunities the university affords.

The desire of the socially insecure person to take part in social affairs and the protectiveness with which he conceals this desire for fear that his security will be further threatened was shown in the following reply:

"I am still a little shy about attending parties. I haven't been persuaded enough. Poor dancing keeps me away from such parties. Long school hours along with working hours keep me home to rest."

One man who had worked out a method of overcoming his sense of inferiority, or at least concealing it on social occasions, gave in his philosophy some advice to his socially inferior classmates:

"I say, Why fear any one? Think of something to say to a stranger and get him to start talking. Talk about something that has to do with the present—something both can see, hear, or understand. Be straight in your speech and talk as though you have known your stranger for a long time. I speak to all people as I would to my friends. Laugh or smile with them, and don't say 'no' or 'yes'—always color or lengthen your answer when possible. I mean don't be snappy, short, and curt in your answers, for it sounds too much like crabbiness. If you discover that the stranger knows some people that you know, he will talk more freely and more friendly to you. Or perhaps you have been through the town or country where he lives and then can talk about something more common. Always I talk about those things that appeal to the interests of my stranger. If he likes to hunt, then I like to hunt, and we talk about hunting; if he is a fisherman, I am a fisherman; if he is a historian or musician, then I am a historian or a musician. Never force any one to talk; if they won't, then take it as 'O.K., don't. It's O.K. with me.' You will find a few of those people. Generally most people will talk if you encourage it a little.

"I believe your approach is very important. If at a dance, never take a stranger by surprise. Let the girl notice you. Make some sort of hint with your face to let her know you are coming towards her and intend to ask for the dance. She has time then to 'size you up,' and if you don't rush in your actions and talk about the music, friends here, or that you're all alone, or ask that question and then, 'Have you this dance?' or 'Shall we dance?' it brings almost invariably proper results. I have been dancing for five years and go to dances alone the greatest number of times, and have had only two girls who refused to dance with me without a real and proper reason.

"People have told me that I make acquaintances very easily, and many tell me their troubles that they wouldn't think of telling to their boy or girl friends or to their parents. Several write to me and ask my advice about friendship and love affairs and what I would do. I always answer—say just what I think and believe always to be very frank. Try to remember names and call them by names when you see them is very advisable."

It is significant of the extent to which feelings of inferiority infiltrate into personality that his elaborate rules of etiquette have failed to eradicate the trait in him.

While the foregoing examples afford considerable insight into the complex of inferiority, it is further illuminated by a correlative study of some objective factors and feelings of inferiority in a selected group. The graduate male students were chosen because they represented the highest proportion of feelings of inferiority and because they formed a somewhat homogeneous group, in that the factors of sex, college, and class were constant. For 63 male graduate students it was possible to obtain data on:

1. Age
2. Sibling position
3. Socio-economic status (as measured by father's occupation)
4. Family income
5. Present family status
6. Population of home town
7. Percentage of expenses earned previous quarter
8. Working philosophy of life
9. Living quarters at university
10. Number of new acquaintances made since coming to the university
11. Number of intimate friends
12. Fraternity membership
13. Credit hours carried
14. Amount of money spent on recreation per quarter
15. Number of hours per week devoted to recreation.

Of this group of students, 42.9 per cent admitted to feelings of inferiority of such severity that they were considered a

significant obstacle to attaining happiness and satisfaction; 57.1 per cent did not list feelings of inferiority as a handicap. The technique used throughout the study was to compare the inferiority group with the non-inferiority group on the various factors. There was found to be no significant relationship for this group between feelings of inferiority and the factors of age, present family status, percentage of expenses earned previous quarter, living quarters at the university, number of intimate frinds, fraternity membership, and number of credit hours carried. Positive findings were as follows:

1. Having an older brother or brothers increased the tendency towards feelings of inferiority, while the presence of older sisters decreased it. Oldest children had a proportionately low percentage of inferiority feelings, while youngest and only children had high proportions.

2. The relationship between feelings of inferiority and socio-economic status as measured by father's occupation was found to be inverse—as socio-economic status declined, feelings of inferiority increased.[1] Of those students whose fathers' occupations fell into the I, II, and III categories, 32.1 per cent had feelings of inferiority; of those whose fathers' occupations fell into the IV, V, VI categories, 47.1 per cent had such feelings.

3. The relationship between income and feelings of inferiority was also inverse. Of those whose family incomes were below $2,500, 52 per cent had feelings of inferiority; of those with incomes above $2,500, 38 per cent had such feelings. For the larger group of 1,453 male students, a tetrachoric correlation coefficient of +.128 was found between feelings of inferiority and economic insecurity.

4. Students with feelings of inferiority tended to come from the larger towns and cities. For those coming from communities whose population was under 10,000, the percentage of inferiority feelings was 36.0; for those with home towns of more than 10,000 population, the proportion of inferiority was 48.6 per cent.

[1] The classification of occupations was based on the Minnesota occupational intelligence scale, which bases its classification on the intellectual and educational requirements of a given occupation.

5. There was a tendency for feelings of inferiority to be accompanied by a utilitarian philosophy of life.[1]

6. The data on number of new acquaintances made since coming to the University of Minnesota showed that of those students who made less than 25 new acquaintances, 52.4 per cent had feelings of inferiority; of those who made more than 25, 38.6 per cent had such feelings. For the group of 1,453 male students, a tetrachoric correlation coefficient of +.360 was found between feelings of inferiority and lack of social contacts. We do not know, however, whether those with feelings of inferiority had fewer opportunities to make acquaintances, or whether they had equal opportunities, but were prevented by their personality difficulties from capitalizing on them, and rationalized their consequent lack of social outlets by calling it lack of social contacts.

7. A slight tendency was observed for those with feelings of inferiority to spend more money per quarter on recreation. Of those who spent less than $15 per quarter, 42.4 per cent had feelings of inferiority; of those who spent more than $15, 50.0 per cent had such feelings. However, when the factors of family income and percentage of expenses earned were held constant by matching students in the inferiority group with those in the non-inferiority group, the difference between the means was not significant.

8. Those with feelings of inferiority spent significantly fewer hours per week on recreation. Of those who spent less than ten hours, 52.2 per cent admitted such feelings; of those who spent more than ten hours, 23.5 had inferiority feelings. When pairs in the inferiority and in the non-inferiority group were matched on the basis of number of credit hours carried and of percentage of expenses earned (as a rough measure of time spent working) there was a significant difference in the mean number of hours per week devoted to recreation ($^{D}/_{D} = 2.13$).

We are justified in concluding that although there is no accurate measure of the extent to which feelings of inferiority are present among college students, they are more prevalent than is ordinarily supposed. In spite of the fact that a feel-

[1] For a discussion of the classification of philosophies used, see Fenlason, *op. cit.*

ing of inferiority is usually considered of minor importance, it may be a serious handicap to an individual's future adjustment and is recognized as such by the student. He is conscious and articulate about this defect in his personality. While little is known of its exact components, such factors as lack of social contacts, financial insecurity, and adverse home conditions have a definite relationship to feelings of inferiority. In an examination of a group of graduate male students, the additional factors of sibling position, socio-economic status, family income, and population of home town were found to have a significant bearing on feelings of inferiority. These feelings are ordinarily bred before the student comes to the university. His mere presence at the university is not enough to eradicate such psychological handicaps; it is more likely to augment them than to decrease them. A better knowledge, based on individual studies, as to the extent and content of such feelings, may point to ways of prevention and treatment.

THE CONSCIENCE DURING ADOLESCENCE *

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EXPERIENCE in many contacts with the emotional problems of adolescence almost leads one to believe that there is such an entity as a puberty neurosis. The reactions of the boy during puberty to the stresses of his instinctual life and his efforts to transform them into socially useful expressions often lead him into behavior patterns that are temporarily pathological. One does not like to classify these reactions in the ordinary nosological groups, because of their fleeting expression and because one gets a feeling that they are somewhat different from the cases that we ordinarily place definitely in a diagnostic category. For these reasons one feels that this type of neurotic reaction is characteristic of and caused by the shifting tides of emotion during puberty.

The period of puberty is one of profound emotional change; one might truly call it a period of emotional metamorphosis. Puberty is really the era of great change from the semi-passive object relationship with the family during childhood to the independent guidance of one's own destiny in adult life. The child is essentially in a passive or semi-passive relationship with society, at best. He is still the object of his parents' love and attention at home; he is the object of the teachers' efforts at school. And from too many angles he is only the object of training into social usages and customs. In adulthood the normal male has a quite different orientation. He is, or should be, the master. He selects his own objects—or is insecure if he is unable at least to feel his capacity to do this. The change from the passive attitude of the child to the secure, active attitude of the adult is one that must be accomplished in the normal development of the adolescent. But he is often very insecure in his feeling about his capacity to make this transformation. And the whole problem of the

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boy's sexual life is one that comes up abruptly for solution at this time. The sexual drives that demand activity and the social *mores* that demand repression are engaged in a tense tug of war.

It is not unusual, therefore, for puberty to appear to have distinctive emotional reactions from the psychiatrist's point of view. At this point I shall roughly describe our classical so-called puberty neurosis as hysterical in type and largely based on character difficulties of an hysterical nature. One gets predominantly anxiety reactions, phobic reactions, some compulsive tendencies, schizoid reactions, feelings of inferiority and insecurity, and fears for the future. Beneath the braggadocio of youth one discerns the boy's own question as to his powers. Depressive episodes are quite common if the anxiety has gone on for any length of time. These depressions are purely affective in type, usually showing none of the graver manifestations of true depressions, and fleeting in character, here to-day and gone to-morrow; they may also be back again day after to-morrow for a short stay. One encounters great difficulties in concentration, profound tendencies toward daydreaming, and a general inability to find in the task at hand a real, personal meaning. This whole substratum of symptoms is often well rationalized and covered over by general philosophical considerations. Is life worth living? Has it a purpose? Has it a meaning? Is religion only a mirage? Is idealism a purely Don Quixotic phantasy? Have higher education and training only served to destroy something fine within the individual? These and other ruminations of the kind may often be the presenting symptom which covers over the underlying manifestations outlined above. The condition may be only a fleeting one, perhaps recurring occasionally until the phase of puberty is passed and an adequate expression of emotional needs in maturity puts an end to the symptoms. On the other hand, this may be the introductory period of a definite neurosis or psychosis, or of the structuralization of symptoms into permanent character disorders of a more severe nature.

Now the question comes up, What in a general way does this phenomenon of puberty neurosis represent? I think that those cases with mild manifestations which recover readily best reveal the nature of the reactions that are going on.

My experience has taught me that the problems of puberty neuroses are best understood and treated by a thorough knowledge and understanding of the activities of the conscience during that period. We need to know the forces that prompt its formation, its structure, and the sources of executive energy at its disposal (by this I mean the anxiety which one constantly sees in the neurotic problems of puberty); and lastly, we want to know about the potentialities for sublimation of the demands of conscience—how these strivings can be converted into non-neurotic, stable, and valuable character formations, helping the boy to fulfill his destiny and to use his emotions in ways that are acceptable from the social point of view.

Freud, in his *Three Contributions to the Theory of Sex,* has given us a masterly discourse on the formation of conscience in early childhood. We know from this work that at the onset of puberty the conscience expresses itself in accordance with the patterns formed in early childhood. In childhood the conscience is the heritage of thousands of frustrations to direct instinctual tendencies, and the sum total of these situations forms a powerful intrapsychic structure whose voice is always heard, because of the anxiety it has at its disposal. This comes about because of the child's tendency to identify himself with the person who frustrates him. For example, a little boy who had been scolded several times by his parents because he did not stay in bed one night, was heard later saying to himself: "If you get out of bed, I'll lick you!" One sees from this illustration how the child identifies himself with the parent in an effort to overcome the hopelessness of his passive position. We also know that after this psychic experience the child is not just the same as he was before—a new tendency toward restraint has been established by the introjection of the frustrating object. As I said above, the sum total of thousands of such experiences determines the ultimate structure of the conscience. And why are these tendencies so strong in the child? From whence comes the powerful anxiety at the command of the conscience?

The outstanding characteristic of the newborn infant is his great biological insecurity and his dependence upon his parents. This situation must always be an unquestionably secure one if the child is to be happy. The child also has another

very important tendency—his early need for body pleasure. The function of nursing at the breast not only fulfills the need for food and nourishment, but also provides the child with real pleasure of a sensual nature. If this is not found to a sufficient degree in the act of nursing, thumb-sucking soon follows. During this period we see a powerful demand for adequate expression of these two needs of the child: (1) the need for a feeling of security with those who care for him and (2) the need for sensory gratifications of the erotogenic zones in the body. These two needs—the affectional and the sensual—fuse and, along about the age of three or four, find their expression in a form that is definitely sexual.

At this time the genital organs become the most strongly sensitive erotogenic zone in the body and the child's intense feelings turn thereto. The result is a period of infantile masturbation and luxurious phantasy life, associated chiefly with the parents and questions of procreation. These interests soon become a threat to the child's feelings of security; he soon feels, "This is a bad thing to do. Those are wicked thoughts to have. If Mother and Daddy know about this, they won't love me." The power of the child's instincts incorporated in these activities is very great, and highly traumatic events easily arise out of these intense emotional situations. The child cannot easily give up his source of pleasure; he cannot possibly endure the thought of not being loved; and it is almost impossible for him to travel a straight course between these two needs without being upset a great part of the time.

During this period the infantile neurosis occurs, characterized by night terrors and, at times, by specific phobias during the day. We know now that the instinctual life of the child is already being repressed by the anxiety expressed in these symptoms. In an overwhelming majority of cases, the end result is the triumph of anxiety over the instinctual life and the repression of the phantasy life and masturbatory tendencies. The effect on the child of the frustrating parent seems always to be most powerful within the field of the child's emotional life that has to do with affectional and sensual needs. The energy components of these activities seem quickly to turn to anxiety if interfered with, and the child readily develops its anxiety dreams and phobias thereby.

This is a striking and profound reaction and one that very frequently turns into fear of actual bodily mutilation. An age-old testimony to the truth of this is the themes of our time-worn children's stories—*Little Red Riding Hood, The Three Bears, Jack and the Bean Stalk, Little Goldilocks,* and so forth. The child cannot help being concerned with that which is so important to him at this time.

After this we enter into the latency period, a relatively quiescent phase from the point of view of emotional intensity, which lasts until puberty, when again flares up the battle of the instinctual tendencies versus the conscience, which has meanwhile been building itself into a definite structure. At puberty we see the appearance of strong idealistic tendencies, which are evidence of the attempt to express the demands of conscience in a fully acceptable and socially valuable way. These fulfill the need of the old feelings of dependence. "If I am the perfect boy, I shall always be loved," and contrariwise, "I am anxious if I am not the perfect boy, because I cannot endure not being loved. Therefore, I shall be the perfect boy."

This, however, usually represents an intrapsychic conflict as well as an external one, because the boy at this time cannot endure tensions between his personality and his conscience any better than he can endure tensions between himself and those he loves in the outside world. His conscience and the outside world will have very little of the powerful demand that his sexual life is making for expression, and so we have a split between his idealistic life and his sexual life. The appearance of sexual needs is received as a threat, and anxiety dominates the boy's whole reaction toward them. But he still has the problem of discharging the energy inherent in his repressed sexual drives. The commonest response in the neurotic boy is the creation of a pseudo-idealism, which holds the family love intact, but which also allows him excessive secret gratification in the form of masturbation. This is carried on with a great sense of guilt, arising from the anxiety, and the problem of how to deal with this sense of guilt becomes a very pressing one. We find that the sense of guilt and the anxiety are the transformed sexual energy which cannot be directly expressed, but is rather repressed and later

finds expression in these transformed feelings of guilt, and so on.

Actually, the most important question for the boy in this period is how to deal with the anxiety and the sense of guilt that arise out of the situation outlined above. We see now that the conscience wields the weapons of feelings of guilt and anxiety, and has taken over command of the situation. In infancy we saw that the instinctual life ruled the situation; now we see that the conscience is in the saddle. The baby is a creature of instinct and its demands; the adolescent is the creature of conscience and its demands. And the conscience has at its disposal the power that was in the instinctual life in early childhood. The only exception to this rule among adolescents is the boy of pure criminal type, who is indeed a rarity. By pure criminal type—the type of boy who can express his instinctual life directly in antisocial acts with no sense of guilt—I do not mean the delinquent boy who is really an anxiety-ridden lad, with the same problems as the non-delinquent, but a less stable conscience, who is less able to form idealistic outlets and so seeks release from his anxiety in the excitement of antisocial acts. This boy shows the same guilt reactions and the same need for punishment as does our neurotic boy.

In the ordinary boy, the instinctual life is repressed by means of his normal conscience; he is relatively free from anxiety most of the time, as he is capable of more or less directly sublimating his repressed primitive tendencies. In the neurotic boy, we find that unstable reactions against the instinctual demands take place, and this energy finds outlet in excessive activity of his conscience. We find a pseudo-idealism developing which in no way takes into account the demands of the real world; we find an extensive phantasy life, and at the basis of this, the wish actually to return to the attitudes of earlier childhood, where the boy seemed safer and his need for dependence was fulfilled. The insecurity in these attachments is so great that he cannot give them up to find newer and more mature ones to fill his developing needs.

We must differentiate here between the pseudo-idealism of the neurotic and the normal idealism which finds for the boy an adequate solution of his personal and social needs.

The boy in the grip of neurotic difficulties in puberty must find some way of dealing with the anxiety to which he is constantly subjected by the attacks of his conscience. If, as he develops, he throws off his neurosis and becomes normal, he converts his pseudo-ideals into practical ideals and measures his critical attitude toward himself by a standard based on objective relations with the real world; he finds joy in constructive activities; he finds older men with whom to identify himself, and in this important way, changes the attitude of his conscience to conform to the new pattern found in his friendships; his work becomes an outlet for his aggressive needs; he finds an increasing personal meaning in the social values of his endeavors. These constructive avenues of energy discharge take the place of the old anxiety which formerly was his major emotional outlet. His development is along the line of stable character formation and not, as previously in the neurotic state, in insecure, unstable reactions which force him to be constantly on guard against his inner emotional tendencies.

On the other hand, if the neurotic boy is incapable of resolving the conflicts with his conscience, he must find immediate means of relieving himself of anxiety; inadequate, unstable, and only for the immediate moment though these measures may be, they must be accepted, as they are the best he can find. They are the symptoms which I mentioned earlier as the ones we commonly find in a boy under these conditions. Conscience is in the saddle with the whip of anxiety at its disposal, and the boy continues to suffer.

In my early years as psychiatrist at Dartmouth, I had a boy who, in the course of our talks together, remembered that at the age of five, he crawled out on the ridgepole of a one-story ell, became frightened, and cried for help. A neighbor came to the rescue. An event like this is of no immediate importance in the hectic life of a child, but it becomes of importance to us when I tell you that every day for about two weeks, he repeated this act. The explanation of this repetition of a painful scene is simple: (1) the tremendously powerful tendency of the unconscious to repeat situations that have not been mastered, in the hope of thereby gaining a mastery, and (2) the thrilling excitement gained from the danger situation.

We must now bring these two formulations of our little lad's behavior in relation to the neurotic boy's reactions to his conscience. Where the normal boy tries to find a secure and stable answer to the problems of conscience by adapting its needs to the social situation, the neurotic boy repeats over and over again anxiety situations in which his conscience dominates him. In these situations he finds a thrilling excitement, just as did our little fellow on the roof. It may, at first, be difficult for him to perceive this element of gratification consciously, but repeated endeavors bring to him the conviction that the unconscious gains a surreptitious pleasure in the excitement created by the tension of the situation. Without insight, the conscience may become more brutal and more sadistic, until this reaction pattern, one way or another, almost dominates the boy, and at this point we get the classical picture of the puberty neurosis, which I defined for you at the opening of this paper.

And now as to the question of treatment. The aggressive and brutal conscience must be modified; this is the nucleus of the problem and, by and large, our therapeutic endeavors are fruitless unless some permanent alteration in the attitude of conscience is accomplished. The most immediate, effective weapon that we have in our hands is the powerful emotional relationship between the psychiatrist and the patient, which is called the transference—a relationship of which youth is readily capable. The proper use of this transference situation is of paramount importance in the solution of the difficulty. In the grip of the problem of handling his conscience, the boy is constantly seeking new patterns, and when an adequate older parent-substitute comes into his field, he grasps eagerly at the new model. The psychiatrist is in a peculiarly happy situation for bringing about the necessary transference situation. The boy readily accepts him as an ideal figure, and in this relationship, neurotic pseudo-ideals can be changed into practical working ideals; the aggressive conscience can be modified, because the psychiatrist's conscience is a nicer one, and the boy wants one like it. It is a greater joy to be like the psychiatrist than to have the thrill of being whipped by a neurotic conscience. It is surprising to see how new vistas of an interesting life open up for a boy under these circumstances.

The psychiatrist must be able to understand quickly the unconscious conflicts that really lie at the bottom of the problem. He must be able to feel as well why the boy has been unable to resolve these conflicts and to develop adequately instead of neurotically. And with this understanding of the boy as a case, he must, at the correct time, point out to the patient those elements of his unconscious emotional life which need to be brought into consciousness at this time. He must also be very wise and know that part of the boy's unconscious emotional life should not be brought to the surface. Grave errors can be made by abrupt and premature exposure of unconscious situations, and acute anxiety attacks precipitated thereby.

The psychiatrist should also be fully aware of the nature of the emotions at play in the transference situation—both the patient's emotions and his own. This is a *sine qua non* in the proper management of these cases.

One must not get the impression that the psychiatrist gives a *carte blanche* to sexual activity; this, indeed, would be an error, because it would merely provide an adequate later opportunity for attacks by the boy's conscience, which would surely swing back to its old attitude of aggression again. What is really needed at this time in the boy's life is not so much direct, sensual gratification as the other elements mentioned in the early part of the paper—the feeling of security in relation to his affectional needs, and the feeling that life will hold for him adequate gratification of his sexual needs and that he has the power to find his way to this fulfillment. It is often true, however, that the boy has become very insecure regarding the fulfillment of the affectional and sexual aspects of his love life. He is thereby thrust into the grip of an emotional struggle. Out of our contacts with the boy, we hope to gain for him the achievement of the point of view that life will, in time, offer and that society will allow him some adequate expression of his love needs, affectional and sensual. This is the point of view that the boy needs, and with it, of course, a capacity to use his emotions constructively in the direction of personal gain. No longer does he need to find an outlet in symptoms that result from his neurotically cruel conscience.

EVERYDAY MENTAL HYGIENE AND THE EVERYDAY TEACHER

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SAYS Popeye, "I am what I am."

The psychiatrist of to-day would say, "But you might have been what you are not. Had the family income not been enough for that muscle-building spinach which saved you many painful beatings in those early boyhood fights, you might have been a coward.

"Had your father felt it his duty to break your will by thrashing you soundly after each fight, you might have been a 'yes' man.

"Had your mother kissed your bruises and sympathized with your pain, you might have been a sissy.

"Had you suffered frequent frustration in home and school for which you found fighting a satisfying compensation, you might have been a bully.

"Had your wants far exceeded your resources for satisfying them, and had no intelligent guidance in bringing wants and resources into balance been available, you might have been a gangster."

The psychiatrist of to-day does not agree with Watson's early theory that any one may develop any way of life for which he has the requisite physical structure, but he does say that every new-born infant has potentialities for several ways of life and that everyday experience helps to determine which he will develop.

This deepens our responsibility as teachers. Wittingly or unwittingly, we are helping to determine which of each child's potentialities are to be developed. If we are to guide wisely, we must develop sensitivity to the evidences of thwarted and distorted growth and acquire knowledge of, and skill in removing, the causes of such thwarting or distorting. Two ques-

tions must ever be before us: "Do I understand why this child is doing what he is doing?" and, "Is what he is doing conducive to a happy and effective way of life?"

What the "everyday teacher"—meaning any of us—can do in the "everyday school"—meaning the school of any of us—to develop the potentialities that are most promising from the point of view of effective and zestful living, is suggested in the true stories I am about to give from the experiences of everyday teachers in everyday schools. At least, I hope they are "everyday schools," although I am afraid they are not typical in three essential characteristics—namely, number of pupils (around thirty), superintendents who permit flexibility of programs, and school boards that can afford an average annual expenditure of about one dollar per child for books and other equipment.

Educators are just beginning to realize what a handicap being "crippled in the tongue" is in mental and emotional development. Walter was crippled in the tongue. At nine years of age he was below the level of the two-year-old in language development—that is, he expressed ego-centered wants and commands in two- or three-word sentences. Only those accustomed to listening to him could recognize the words he was trying to say. Moreover, he was "stupid." Small chance for the physically handicapped boy or girl who is mentally defective, too! So Walter had been "sitting" in school for three years. He was docile, too inert to make disturbance in schoolroom or on playground, so his first three teachers let him sit and forgot him.

Then Miss A came. She visited his home and steered the conversation to the topic of his babyhood. His mother beamed as she told what a "good" baby he had been: "Why, he would sit for hours in his high chair and never make a sound. He never was any trouble at all."

Miss A also discovered that Walter's father did not like fresh vegetables, and that the usual family diet was potatoes, pork, and pie.

Verbalized activity is essential to the development of ideas. Walter had had little stimulation to such activity. The first impetus to activity is the energy within, and Walter's diet, low in vitamin content, would yield little energy. What would

happen if he could be placed in a more stimulating environment? Miss A set herself the task of finding out.

She set up two objectives: first, to secure for Walter an energy-building diet; second, to start where he was in language development (below the two-year level) and plan for him the experiences a nursery-school teacher would give children of that stage of development.

She began by getting the mother's promise to take Walter to her doctor for physical examination. The doctor prescribed a diet rich in vitamin content, and Walter showed a rapid increase in vitality. The day after her home visit, she sent Walter with Bobby—a shy boy, who needed the companionship of one even more dependent than himself—to a nearby hillside for modeling clay. Upon their return she showed them how to prepare the clay for use. Sitting at the table with them, she banged and slapped and rolled the clay, chanting as she worked the following rhythmic pattern:

> "*Bang*, bang, bang" (repeated four times).
> "SLAP, slap, *slap*, slap" (repeated four times).
> "R-o-l-l, r-o-l-l, r-o-l-l, r-o-l-l."

First Bobby, then Walter began to chant with her. Then she left them. There was a lot of clay, but neither Bobby nor Walter rebelled at the monotonous work. So they sat for three activity periods, chanting and working. Occasionally Bobby started on a new chant, as, "Bang the clay, slap the clay, roll it and roll it" (repeated). "I bang it. I bang it. I roll it. I roll it. I slap it with my hand. Now it's nice and smooth, nice and smooth, nice and smooth."

The fourth day Miss A sat down with them and modeled her pet dog. As she continued to work, she verbalized each step. As soon as Walter was verbalizing in similar fashion, she finished her dog quickly and left.

After they had made their dogs, they made other farm animals and barns and sheds to house them. When Miss A saw that Walter was ready for another step, she sat down with them again and dramatized the story of the little red hen with the animals they had made. When she had finished, she left without saying anything. Bobby immediately started to dramatize the story again. Walter coöperated by coming in lustily with the "Not I!"

Bobby read *Wags and Woofie,* and on succeeding days they dramatized incidents from that and other animal stories. One day late in the second month of this program, Walter came to Miss A before school and with considerable struggling told how he had chased their pigs back into the field the night before. She showed him the pictures of the story of the little boy chasing the pig in one of the Baker and Reed *New Curriculum Readers,* and read him the story. He took the book home to tell the story to his mother, and told it to Bobby and to several of the first-graders until he had it memorized. Then she suggested that he could read it, and helped him to move his marker under the line he was "reading." The third day he said, "This line is just like this one." Then she knew that he was ready for reading and suggested that they read the first story in the book together.

Walter learned to read slowly. At the end of the year he was ready for second-grade books, so they kept him in the second grade another year. But he finished third-grade work in one year and has been making slow average progress since. He moves purposefully now, and although he talks little, he becomes a part of any group he enters very quickly—probably because of the eagerness with which he enters into their plans. It is not likely that Walter will ever be a salesman or a teacher, but he is living happily and zestfully because he has an inquiring mind and a tongue that can inquire.

Ralph was making average progress in reading and arithmetic, but Miss B felt that his baby talk might be keeping him from more rapid growth. The doctor reported no structural defect. Evidently there was some emotional disturbance that was keeping Ralph infantile.

A visit to his home showed a mother of superior intelligence and knowledge of child care. There were good story books and a game and work room in the basement for Ralph, and the conversation revealed that he had adequate, but not too difficult home responsibilities. There seemed to be no cause for emotional disturbance.

Miss B visited again when the father was at home and found him to be a great practical joker. Perhaps his teasing was a little too strenuous for Ralph and was causing him to keep himself infantile in self-protection. Tactfully she suggested

that the father reduce his teasing to tolerable limits and be more of a pal in serious pursuits—taking Ralph down to his workshop, for example, explaining "whys" and "wherefores," and letting the boy experiment with tools and materials. Ralph began to grow up immediately. His baby talk ceased. There was a marked quickening in intellectual curiosity. That year his recorded I.Q. rose from 95 to 120. He has done superior work ever since.

Helen had a malformed palate which made understandable speech very difficult for her. She had frequent temper tantrums, which Miss C concluded might be due to the continual frustration of expression. Helen was an average reader, but liked to read only stories on first- and second-grade levels. She was indifferent to all other school activities. Miss C sought to develop some means of expression other than the verbal, but writing, art, and music did not appeal. Miss C then tried reading some very dramatic stories to Helen and noticed how she unconsciously posed for each character, so pantomiming and creative dancing were inaugurated. Helen's eager response was evidence of her hunger for a means of expression. Later Helen became interested in manipulating the puppets for a puppet show.

During the next few weeks she matured rapidly in her choice of stories. She became scornful of "baby" stories and wanted stories that "gave you new ideas." Moreover, she no longer read stories only. As her store of information grew, she began to work out original puppet shows which "expressed ideas"; for example, "The cave boys and girls had to study and learn things, too," or "How children talked to each other before they had language." Other children worked happily under her guidance. Helen will always be "crippled in the tongue," but it is no longer so great a handicap because she has been helped to the discovery that a tongue is not essential for satisfying and effective work and play with others.

Donald was doing high average work in reading and low average in written expression, spelling, and arithmetic, but his sullen, negativistic attitude suggested thwarted development. Watching him closely, Miss D noted that he brightened when he looked at pictures. Acting on this clue, she

took the group on a trip to the art gallery. Donald wandered along passively with the rest until he came to a painting of an old stone house nearly hidden by giant elms. He stood before this almost ten minutes, then walked a few steps and pulled another boy over to look at it, talking to the latter in low tones for several seconds.

The next day Miss D took the class to the woods. Donald wandered away alone. He walked home looking down at the ground and scuffling the leaves.

During activity period that afternoon, Donald went to an easel for the first time and painted vigorously. As he stepped back to survey his finished picture, Miss D paused to look, too. He glanced at her suspiciously and defensively, but evidently sensed her genuine interest and explained shyly, "It's how the woods sounded to me to-day. This," pointing to chiffon-like blue-violet covering the paper, "is the silence and these," sharp wedges of yellow tan, "are the crackling of the leaves."

Acting on this further clue, Miss D read to the class *Waterless Mountain,* the story of a Navajo Indian boy, sensitive to all the beauties of nature. Donald listened avidly. He worked at the easel every day, painting the scenes he imagined as she read. At other times, he wrote the story of the pictures in language that retained much of the beauty of the original, and bound pictures and stories into a book which he shyly gave Miss D for the room.

Meanwhile, Miss D had visited his home, finding an ultra-practical, bustling mother, who was impatient with the absent-mindedness of husband and son, and two older sisters cut after the pattern of the mother. The mother was, however, eager to coöperate and willing to use her influence to encourage father and son to take long rambles together in the country. Donald came to Miss D after his first ramble, glowing with enthusiasm, to tell her about a pool fringed with grasses and teeming with tadpoles. She suggested that he take *Wagtail,* by Gall and Crew, home to read with his father.

Donald's recorded I. Q. rose ten points that year and he became the best all-around pupil in the third grade. He never showed a marked aptitude for art—in fact, his interest in painting decreased as his environment broadened. He worked the following summer for money enough to buy a

cheap microscope, and at eleven years of age, the last time I heard of him, his major interest seemed to be science.

Carl, nine years old, was in the second grade. He had a mechanical mastery of the arithmetic combinations, but could solve only those problems on second-grade level which involved money. He could not learn to spell. His I.Q. on a Binet test was 70. It was obvious, therefore, that his mental age was only then sufficient to permit him to learn to read. His beginning three years too soon had fostered impeding habits. It was necessary to start anew with a reading-readiness program. This his teacher did. His father had a grocery store. Miss E. read to him *The Grocery Store,* one of the *Social Science Readers,* and asked whether he would not like to make a book about his daddy's grocery store. He beamed. So they began. He drew the pictures. She wrote the story about each that he dictated. In doing this, she so guided his composition that sentences would be short with much repetition of words. Before they had finished, he was noticing similarities and differences in words.

She then turned his attention to the sources of the products in his father's store. After they had talked about wheat, she gave him the primer on wheat, which she had written out in manuscript form. He read this in two weeks. When he had finished, he exclaimed, in awestruck tones, "I've read a book! I didn't know I could learn to read." He then attacked the other preprimers, containing less challenging material, with eager interest in exercising his new-found powers. Miss E did not hurry him. He read twelve preprimers before undertaking a primer. At the end of the year, he was able to read easy first-reader material.

In like manner she began again in arithmetic by having him combine and separate and compare groups of objects until he *knew* each of the numbers to *ten* in all its relationships with other numbers under ten. Then he learned that those combinations of meaningless figures which he had been parroting expressed these relationships. He also learned how this understanding of quantitative relationships increased his understanding of daily happenings out of school. For example, he liked to discover how many more days that box of oranges from California had been on the train than the

box from Florida, and how many miles the bananas had been carried on a donkey's back.

It was another year before he was ready for third grade. Carl will probably develop slowly. He will probably complete the seventh grade at sixteen and go to work in his father's store. But he has started on an effective and zestful way of life. He can read, write, and compute adequately enough to be an efficient manager of that store. He has interests that promise to carry him into all the far-away places from whence the products within those walls have come. This will add the touch of romance and the personal interest in the lives of other people that make living more interesting.

June *couldn't* pay attention. It was a temptation for Miss F to scold her, reminding her that she wouldn't pass if she didn't learn to pay attention. But Miss F did not do that. Instead, she went to June's home. There she found a tyrannical, hypochondriacal father who could not tolerate noise and alibied his obsession on the ground that "children should be seen, not heard." The mother was a mouselike, overanxious woman who was continually hushing the four children.

So Miss F did not scold June for not paying attention. Instead, she resolved to find something in which June could become so absorbed that she would have a few minutes freedom now and then from that overburdening anxiety of disturbing, and being "yelled at" by, father. Perhaps something dynamic to observe would do it. So they brought part of an ant hill into the schoolroom sealed between two panes of glass. June forgot herself for ten or fifteen minutes at a time watching the ants. After several days she began to question. Miss F suggested that she might find the answers to her questions in Gall and Crew's *The Black Ant*. The reading was difficult for June, but she was sufficiently interested to struggle, so Miss F showed her how ability to analyze words phonetically would help. June went to work with a will. In three weeks she could get most of the strange words for herself. As her curiosity about ants was satisfied, she began to be curious about other creatures. One day she brought a spider to school and said that she wanted to watch that. She found a third reader that answered her questions about spiders. After she had read that, she read the rest of

the book. One day she remarked in a surprised tone, "I've read a book *through!* I never thought I liked to read books."

The satisfaction she got from mastering phonics evidently led her to want to master the number combinations, which she did not know. Miss F showed her how she could go back to the beginning by herself and *learn* each of the numbers by analyzing it into all of its combinations and comparing it with groups of other numbers. At the end of the year, she was standard for entering fourth grade in everything. Unfortunately, the fourth-grade teacher was her father in a slightly milder edition. She grew highly distractible again and made no progress. She moved away a few months later, so I know nothing of her later progress.

Anne, in the fourth grade, was making average progress, but she was tense and getting things only mechanically. Investigation revealed a home in which she had absolutely no responsibility. Maids even hung up her clothes. Her older sister was an outstanding girl, and all the family conversation centered about her. Thus Anne had had an environment far from stimulating to mental growth.

Her teacher worked for a whole year to get the parents to see the problem. At last she succeeded. The following summer the brilliant sister was sent to a girls' camp, and father, mother, and Anne went to a little farm together. Anne helped her mother with the work, and when it was finished, they explored the fields and woods together. Anne blossomed. Moreover, the parents grew to know her and she learned to feel secure with them. The older sister never again was the center of family life. Anne's recorded I. Q. changed from 100 to 130 between the May before and the May after that summer together.

Harry was belligerent in school and on the playground. His parents, anxious for him to succeed, had tried threats, rewards, and punishments, but he refused to "study" and piled failure upon failure. When he was eleven years old and in the third grade, his teacher, Miss G, discovered through a visit to his home that the activity most absorbing to him at the time was shooting with a bow and arrow. She went home, found a picture of an archery contest to put on the bulletin board next day, and spent the evening in the library learning

about archery. The following morning Harry saw the picture as soon as he entered the room. He stood in front of it for some time. Other boys joined him and they fired remarks back and forth for several minutes. Then Miss G casually walked by, heard a question, and answered it. Other questions were hurled at her. She answered several, then suggested that they list all the questions and send a committee to the library to find the answers. She put Harry on that committee.

Later they decided to organize an archery club. Thus the groundwork was laid. Harry was off the defensive with her and with others. Meanwhile she was avoiding conflicts over school work at school and had the promise of the parents to keep hands off at home. The second week she gave a standardized list of words from the Iowa spelling scale, beginning with first-grade words. From the misspelled words of each child she made out individual lists for him to learn that week in lieu of the regular spelling. The ones she selected for Harry were phonetic, with a total of five different consonant sounds and short vowel sounds of *a* and *e*.

During the study period she passed from child to child, giving help in studying. When she came to Harry, she said, "I know a little trick that will help you with these words. You just have to learn to hear each sound. Now I am going to say one of them and you tell me what sounds you hear." In a few minutes he was able to identify the five consonant sounds, but he was having trouble in differentiating between the two vowel sounds. By this time he was too interested to note the fact that he was being singled out from the others as needing more help and was coöperating well, so she continued with practice in discriminating between the vowel sounds.

Then she had the children choose partners, and each spell his words to his partner. Harry came rushing up to show his 100. Her reply was, "Would you like to work that way again? We can spell most of the words we need by just learning to hear the sounds. Then there won't be many of the other kind left." Harry answered enthusiastically, "You bet!" She gave him extra time during the next two study periods; then thought it safe to suggest that the other boys and girls would need time too, but if he could come early, she would help him before school.

Then she discovered that John needed help of the same sort and asked Harry to help John as she had helped him. At the end of two weeks she gave the same test plus additional phonetic words. Harry was overjoyed when he learned that he had spelled every phonetic word correctly. Then they went back to their spelling book. Harry had confidence in his ability to learn to spell now and voluntarily took his words home every night. Miss G had explained to the mother how to work with him.

Miss G next attacked reading by explaining to Harry that just as he had learned to spell by starting with easy words, so he could learn to read by starting with easy reading—that it would be baby stuff, but he would just have to make up his mind to tolerate "baby stuff" if he wanted to learn to read. So they started with primers. The phonetic discrimination he had developed in spelling helped him and his mental age was beyond that required for learning to read; consequently he learned rapidly. He read his fourth preprimer in one day. Then preprimers became his library reading-hour diet until he was promoted to first readers.

Three months from the day Miss G aroused his interest in archery Harry was beginning a second reader. Six months later he was beginning a third. He was promoted to fourth grade the next year, although slightly below the others in reading ability, but he continued to gain during the fourth grade and was promoted to the fifth at the end of that year.

There are hundreds of school failures in our nation who are growing up to be misfits. Some educators have estimated that as many as 90 per cent of these school failures are too well endowed by nature to be failures. We cannot tell by looking at a so-called stupid child whether he is stupid because of defective genes or because of defective environment. Therefore, the only safe thing for us to do is to assume that every child is capable of development. The first step is to go forth in search of retarding factors. Three questions to guide the search for these are: Has the child had from infancy the stimulation for activity—manipulation of and experimentation with materials and with verbalization of such activity—which is requisite to the development of ideas and language with which to remember and express those

ideas? Have the activities for which he has had opportunity been on his mental level? Has he been free from strains and stresses which tended to create emotional preoccupation?

If a child continues to develop slowly in the most favorable environment we can create for him, we should turn our attention to developing his compensatory abilities. For example, Carl will probably never find reading easy enough to make it a major interest, but he can live a more effective and happy life as a grocer as the result of the stimulation and development of a questioning spirit that razes the walls of his side-street grocery and makes him a brother to all mankind. Helen's conversation will never be easily understood, but she is happy and effective in life because she has learned other ways of communing with her fellows.

These children, with potentialities for growing up either as happy, effective individuals or as misfits, are challenging the school to help them develop to the highest degree their possibilities for usefulness and happiness. May each school ask, "Are we accepting this challenge?"

ARE WE TEACHING OUR CHILDREN TO FIGHT IN THEIR PLAY?

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GEORGE, when a venturesome pre-school lad, was deeply impressed by his parents' stern and positive demeanor. His mother had adopted that aggressive pattern which sometimes goes for social alertness and ultra-smartness. His father, a successful business man, added heavily to the picture, constantly reminding the boy that the real values in life are to be found in the competitive swim—that one has to swim faster and farther than the other fellow. Viewing life as a struggle for dominance, George's parents considered it their duty to train the child so that he could overcome obstacles and especially people who happened to get in his way. Unable to evaluate these false ideals, which had the blessing of parental emphasis and approval, George accepted them as valid.

These aggressive ideals imprinted upon the child found their natural expression in his overt behavior and particularly in his play experiences. One of the most conspicuous results was a controlling desire to win all the games in which he took part. He was deeply disturbed by defeat, although he tried to hide his feelings of disappointment. He became impatient and critical and even abusive of conditions and people who stood in the way of his egotistic and selfish ambitions. At times he attempted to put forth brute strength against his mates, whom he considered as his enemies. His play became a source and expression of edgy combative conduct, of serious behavior maladjustment, instead of the traditional happy and expansive experience it should have been.

This tragedy of false perspective has done much to make recreation a serious threat to the healthy mental and physical integration of the growing child. Since but a few may win, and since individual winning itself is not the most satisfying objective in a social world in which all seek and have a

right to demand expression, is it not high time that this pernicious and narrow ideal be abandoned by educators and parents?

Some children react to this situation by simply feigning a lack of interest. A ten-year-old boy comes to mind who would sit dreamily on the side lines while others played. He said that he did not like to play. Upon closer observation, however, it became evident that when he attempted to play, in his clumsy fashion, there emerged in vivid and tragic outline the destructive ideal of the all-importance and all-satisfaction of being first, so foolishly inculcated by his parents. Equally tragic were his floundering attempts to adjust to group relationships. True to his teaching, he attempted to become acceptable to others by virtue of his competitive rather than his coöperative capacities for achievement. Since he could not win every time, he attempted to gain attention by becoming different from the crowd. He also posed frequently as the lone champion for some unusual cause in the group interplay of childhood activities and interests. In later life, he was never able to sublimate these aggressive trends, which remained undisciplined to confuse and confound him. The "I do as I like" attitude, so harmful to happy living, was the result.

William, on the other hand, had in early life a happy play experience. His parents, although they had probably rarely used the term "mental hygiene," had much common sense and instilled in their child sensible ideas and ideals. He was taught by practice as well as precept that wholesome play is basically a social expression—that the greatest and most substantial pleasure is to be found in play, not only with others, but also for others as well as for self. He happily realized that one gets more fun in striving with another than in fighting against another conceived as an enemy rather than as a friend.

It was in high school that he experienced serious conflict between these early ideals and the so-called school spirit, which expressed itself in a sort of mob hysteria, an accumulated and augmented venom directed against the rival neighborhood school. This school must be defeated and forever annihilated on the gridiron. The school spirit was built up,

intensified, and focused in a sort of cannonade against the rival institution. "Lick Gilman!" was the cry emerging from the adolescent throat.

This highly charged atmosphere, exciting the aggressive trends of the pupils, which needed guidance rather than stimulation, put William in a quandary. He felt the conflict between the two systems of teaching, that of the home and that of school. He had been taught to feel that a game is inherently a friendly rather than a combative adventure. Now he must go along with the crowd, or be a sissy. The situation was made even more nauseating by the "pep talk" of the muscle-minded coach, who sternly importuned his protégés to make a supreme effort to win; each player was to "get his man." William concluded from this that a distorted frenzy—yes, even an effort of wild abandon—was better than the offense of lacking this powerful school spirit. The quiet and wholesome integration of body and mind so vividly in evidence when a boy concentrates himself upon a pleasurable, yet challenging play adventure had no place in this system of might over mind, a system adapted to the hysteria of the mob, who look on, rather than the needs of those who play.

It was soon discovered by an hygienically conscious play counselor that Henry's domineering attitude in play was simply a compensation for the frustration he experienced in his home environment. His father thought that children should "be bred to battle," and his positive and domineering attitude allowed the boy but little opportunity for initiative and the expression of his natural aggressive trends. Henry simply projected his feelings of disappointment and hatred into his play, seeking in recreation the experiences a restrictive environment had denied him. The correction for this is surely in the home, and the play maladjustment in this case is best considered as a secondary condition.

Many unwholesome emotional outbursts, projections of hate, fights in play, can be traced to the psychological mechanism by which the child projects the difficulties in one situation into another situation. Play provides the ideal mirror for reflecting the child's inner urges and feelings, whose translation into overt behavior may lead to confusion and misunderstanding unless the underlying motivation is studied. The

parent and the teacher as well are becoming more conscious of this fact. They realize that physical expressions of inner maladjustment complicate play; that the peculiarities, the evasions, the excuses of the child may have more and different meanings when we understand these physical expressions as subjective, springing from the deeper wells of behavior; and that these behavior problems are not necessarily resolved by adjustments in play, but are bound up with the whole life of the child, with "his life aim," to use White's illuminating phrase. The adjustment may lie in the field of the physical organism, in the home, in the school, in parental attitude, in all the interplaying forces, environmental and subjective, that make up the child's life.

Education is marching forward, extending its frontiers to include wide and deep areas of play that have in the past been looked upon as fertile sources of physical and sensory satisfaction, but as rather outside the domain of mental adjustment and mental health. Psychologists have pointed out the possibilities of recreation in education, but the psychiatrists have gone one step further and have discovered many lures and clues to more effective mental adjustments through a utilization and promotion of play as a mental as well as a physical experience. Teachers and parents are discovering that play offers an ideal setting for many lessons in mental hygiene. The father, in the modern scheme of things, soon learns to emphasize the three R's of modern education: Recreation, Relaxation, and Restoration. Such is the modern accent on play which perceives values other than physical in recreation. This new concept is based upon the fact that the child, drinking from the fountain of experience, is learning in every relationship—in his informal contacts at home and on the playground, as well as through the heavy formal instruction at school. This new point of view also emphasizes the importance and the validity of the body accepted as not inferior to the mind, and the discovery of the psychologist that conduct is a unity, an integration of body and mind.

There is a pressing need to-day for such a reinterpretation of the function of play. Modern progressive education is concerned with what the child learns in play as well as with how he learns. The parent is most practically concerned with

the relationship of this play knowledge to the child's everyday problems.

Probably the biggest mistake that educators and parents make in attempting to adjust a child's play is to overemphasize the aggressive trends so naturally developed in this expansive adventure. The child very easily gains the idea that dominance, rather than mastery, is the aim; that he must make a great and heroic effort; that he must subjugate something or conquer some one. The valid ideal of mastering self and the physical elements of the game is supplanted by the invalid ideal of overcoming some individual or some group of fellow players. Thus, the fighting instinct is given too great sway and tends to overshadow the socially coöperative values of playing together rather than against one another.

There is probably no more natural setting for the teaching of effective lessons in mental and social hygiene than an informal game, suited to the capacity and the interest of the children. Here the give-and-take enables the teacher to get closer to his pupils and the pleasurable aura surrounding the activity makes a happy atmosphere for stimulating and fixing the practical lesson. Here is the place *par excellence* for an effective emphasis upon the higher social values of play. The thrill that the child experiences in making a play which counteracts a poor play made by his mate may provide the motivation for other socially considerate acts. In many other ways the parent and teacher may select for approbation episodes in play that show the child giving consideration to the interests and welfare of others as well as himself. The overly egotistic and selfish child may learn to merge his individual desires into larger altruistic endeavor when he plays on a class team, and thus becomes part of an undertaking inherently coöperative.

On the other hand, it is most natural for the teacher to emphasize the fighting aspect of play and to make play fundamentally a fighting activity. The child, too, is most sensitively attuned to the fighting instinct, and play brings to the surface many situations which, if not carefully guided, breed individual and class antagonisms. A clash of interests follows intense competition, and the loser may easily find himself hating rather than admiring the winner, who he feels has

climbed upon his back to glory. The public clamors for a winner and places him upon a high pedestal of approval. The so-called "American system" gives the highest regard to the successful individual, who is conceived to be the lone winner in an intensely competitive society. All avenues of life are concerned with so-called modern efficiency, achieved as a result of keen industrial competition. In such a milieu, the natural thing for the child is to seek the exhilarating values that comes from a conception of play as a fighting adventure. If he is to assimilate a saner and more hygienic point of view, the teacher and the parent must show him the way.

MENTAL-HYGIENE CLINICS IN RURAL MARYLAND

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CLINICS conducted by psychiatrists for the examination and treatment of persons suffering from mental disabilities or emotional disturbances have come to play an increasingly important rôle in organized health service in recent years. In many states, dispensary services for mental cases are conducted by state hospitals. In several states—notably, New York, Massachusetts, Pennsylvania, New Jersey, Delaware, Illinois, Michigan, and California—the staff of the state hospitals for mental diseases hold extramural mental-hygiene clinics, especially in cities and towns.[1] In the larger medical centers, also, psychiatric clinics are an integral part of the ambulatory dispensary service.

In Maryland, mental-hygiene clinics have been conducted for years at the Phipps Psychiatric Clinic and the Harriet Lane Home at the Johns Hopkins Hospital and by The Maryland Mental Hygiene Society associated with the University of Maryland. Occasional clinics have been offered from time to time in the larger towns in the state through the office of the state commissioner of mental hygiene.

The need for further extending this service, especially for problem and maladjusted children in rural areas, was impressed upon one of us while conducting child-health conferences in the counties, visiting rural schools, and conferring with teachers and parents about the welfare of their children. Many children presented problems that could not be solved adequately by a routine physical examination or by pediatric

[1] See list in *Directory of Psychiatric Clinics in the United States, 1936*, compiled by Mary Augusta Clark. MENTAL HYGIENE, Vol. 20, pp. 66–129, January, 1936.

advice alone. There was need of experienced psychiatric analysis and treatment. It was to meet this situation—to be able to give to parents and teachers the authoritative direction necessary to enable them to deal intelligently with their problem children—that a group of psychiatrists interested in prevention as well as in the cure of mental disabilities was called together to discuss the psychiatric needs of the rural child in Maryland as a part of a child-hygiene program.

The suggestion that mental-hygiene clinics be established in the counties of Maryland met with the prompt and cordial approval of the county superintendents of schools and of the county health officers. Many teachers and local physicians, also, having learned of the plan, said that these clinics would meet a need that they had long recognized.

The first meeting of the psychiatrists was held in the office of the Bureau of Child Hygiene of the State Department of Health in February, 1934. It was attended by members of the staffs of the following institutions and organizations: Springfield State Hospital, Spring Grove State Hospital, Rosewood State Training School, The Johns Hopkins Hospital, The Mental Hygiene Society of Maryland associated with the University of Maryland, and the Juvenile Court of Baltimore City. The State Board of Mental Hygiene was represented by its executive officer, Dr. George H. Preston. These specialists generously volunteered their services for conducting mental-hygiene clinics. The state was divided into districts consisting of one or more counties, and a schedule was arranged so that the work might begin promptly. The number of clinics per year scheduled in each district varied, according to circumstances, from six to twelve a year. Outlines for taking the preliminary histories and summary sheets to facilitate the subsequent analysis of the cases were prepared. It was planned that histories of the cases in each county be kept in the confidential files in the county health office and that copies be sent to the Bureau of Child Hygiene, State Department of Health, for subsequent review and analysis each year by a committee of psychiatrists.

In 1934 and 1935, 967 patients were examined in these clinics. Seven hundred and fifteen (74 per cent) were between seven and sixteen years of age. As was expected, a large

majority of the patients were problem children referred by school-teachers. In many of these cases, it was possible to make diagnosis and prognosis and to give helpful advice. A surprising number of these children presented physical abnormalities that needed medical or surgical treatment. The experience of these two years was a factor in the opening of several additional schools in the counties for the instruction of handicapped children.

In 1936, 63 mental-hygiene clinics were held in 19 of the 23 counties in Maryland. Clinics in the city of Baltimore and in Baltimore County are not included in this report. The number of clinics conducted in each county varied from 1 to 9 a year as follows:

Number of clinics	*Number of counties*
1	5
2	7
3	1
5	2
6	1
8	2
9	1

Thirteen psychiatrists and their assistants conducted the clinics. The average number of clinics per psychiatrist was nearly 5. Two psychiatrists had 1 clinic each, two had 2, one had 4, one had 5, four had 6, one had 7, one had 8, and one had 9.

Examinations were made of 469 patients, 28 of whom were stated to be return cases. The number of patients seen at each clinic varied from 3 to 20, the average being 7. The largest number of patients seen in any county was 60; the smallest was 3. The average number seen per county was 25.

Of the patients, 289 were male and 180 female; 416 were white and 53 colored.

The age distribution was:

Under 6 years	34
6 to 15 years	321
15 to 21 years	43
Adult	53
Age not recorded	18
	469

One hundred and ninety-four of the persons examined were referred by social agencies, 128 by county departments of education, 73 by county departments of health, 27 by parents, 18 by physicians, 10 by courts, and the others by miscellaneous or unrecorded agencies.

Nearly 75 per cent of the patients referred were more or less retarded in their intellectual development; 165 were definitely feebleminded, 88 were of border-line intelligence, and 33 others were diagnosed as mentally deficient, but the I.Q.'s were either not accurately determined or not recorded. The results of the Stanford-Binet tests were recorded in 378 cases, the I.Q. distribution being as follows:

I.Q.	*Number of cases*
0–24	5
25–49	32
50–69	124
70–79	86
80–89	63
90–109	64
110–119	3
120 or above	1
	378

One example of the many cases of intellectual inadequacy was J. H., a seven-year-old white boy, who was referred because he did nothing in school except create a disturbance, for which reason he had been seated alone. His mother did not realize that he was in any way different from other children or that he presented a problem. He came of a family of which several members had been previously examined and found to present serious psychiatric problems. The father, a World War veteran, was totally disabled; the mother was feebleminded; a sister was in an institution for the feebleminded; and the domestic situation was one of squalor, poor physical hygiene, and inadequacy for the task of training children. The patient was found to have a mental age of 3 years, 8 months, and an I.Q. of 52 (low-grade moron). Obviously, the public schools should not be burdened with the training of this child, who would never be able to undertake even low first-grade work. The recommendation made, therefore, was that he be placed in the state training school for the feebleminded.

School difficulties were the chief complaints concerning a large proportion of the children examined. One hundred and seventy-five children were failing in their school work; mental retardation was suspected in 151. Twenty-four children were referred for truancy. In two cases reading difficulty was a

complaint. Examples of the types of school problem presented were the following:

J. R., a physically healthy fourteen-year-old boy, was referred for advice as to his schooling. Although he had recently been promoted to the seventh grade with an average of D, it was said that he could not learn, made no progress in school, and that larger boys sometimes put silly ideas into his head.

His early home life had been unfortunate. Nothing was known of his father, and his stepfather, who had provided inadequately for the family, had died of acute alcoholism when the patient was seven years old. His mother had been a careless and extravagant housekeeper, who nagged continually and neglected her children. She had periodically left home, had been unable to hold jobs, and in 1930 had been committed to a state hospital. The boy had then been placed in a foster home, where, in spite of his lack of early training, he presented in no way a behavior problem.

On the Stanford-Binet tests, the patient was found to have a mental age of 8 years, 4 months and an I.Q. of 58. He had clearly reached the limit of his capacity to progress in school and was attempting work much too difficult for him. It was recommended, therefore, that he be permitted to withdraw from school, and six months later it was reported that he was happily adjusted helping with farm work.

N. S., a thirteen-year-old white boy, was referred by his school principal with the statement that he was an habitual truant from school and incorrigible. His father was dead and his mother was an intellectually inadequate, unstable, complaining woman who was incapable of maintaining discipline in the home. The patient had been allowed to "run wild" and to frequent beer parlors and places of ill repute. He claimed that he "hooked school" because the boys there picked on him, teased him, and lied about him.

His mental age was found to be about 10 years (I.Q. 77). Obviously sixth-grade work was too difficult for him. It was advised that he be placed in a rural boarding home and that in the rural school he be placed in the fouth grade. This was done, and six months later it was reported that he was making a satisfactory adjustment in the home and was attending school regularly.

P. R., a white boy, seven years, nine months old, was also referred by the school because he was repeating the first grade and was thought to behave like a two-year-old. He liked to attract attention, was inattentive in class, and was generally disobedient. His mother said that he had the "fidgets."

The child, although moderately retarded in intelligence (mental age 6 years, 6 months; I.Q. 84) was capable of doing first-grade work. The outstanding feature in the case was the fact that he had been smothered with maternal solicitude and indulgence. Because of the attention that he had received at home and at various clinics, he considered himself "cute" and continually tried to impress people with his cuteness. The mother, a well-meaning person, was emotionally incapable of seeing the problem as it was, and the social worker was advised to proceed slowly in working with her in the attempt to "de-babify" the child.

Teachers were given advice as to management of the school problems in 84 cases. Special classes were recommended for 77 children, tutoring for 22, school transfer for 6, grade demotion for 16, grade promotion for 2. It was advised that 36 children withdraw from school.

Asocial conduct was a frequent reason for referring cases. Thirty-five children stole, 32 presented sex problems, 21 were untruthful, 18 ran away from home, 4 each were disobedient and fought excessively, and 2 begged. Five rather typical examples are briefly presented:

A. B., a fourteen-year-old white boy, who was physically healthy except for scabies and enlarged tonsils and who was found to be of border-line intelligence (I.Q. 72), was referred because of stealing and failure to progress in school. He and another boy had been apprehended attempting to steal wheat. He admitted having taken wheat on previous occasions and having sold it to merchants. He was placed on probation, and about four months later was caught stealing feed sacks.

This boy was the youngest of eight children. His father, a farm laborer with a fifth-grade education, was unemployed and had never exercised parental authority. The mother was uneducated, excitable, and dishonest. An older brother was in a training school because of stealing. The family lived in an unsanitary, meagerly furnished row house in a slum district.

A. B. had never progressed well in school; for several years he had been in a special class. He was attempting to do sixth-grade work, but was failing in all his subjects. In view of his mental age of 10 years, sixth-grade work was certainly beyond his capacity. In addition to his mental retardation, he was found to have a reading disability. It was decided that removal from his home and a prolonged period of training were necessary. The patient was, therefore, committed to a boys' industrial school.

C. G., a fifteen-year-old white girl of border-line intelligence, was referred because she had twice run away from home, roamed the streets until late at night, associated with men and women of questionable character, had been found in undesirable dance halls, had accepted money from men, had been drunk on at least one occasion, and had contracted gonorrhea. Her father, who had died six months before, was a gambler who had never provided adequately for his family. The mother, who worked away from the home during the day and who was not well, recognized that the girl had passed beyond her control.

The patient was the third of ten children, three of whom were dead. A brother was on probation because of thefts and truancy. The home was in an undesirable neighborhood, located near several houses of questionable character. Although presenting no behavior problem in school, the patient had repeated the second, fourth, and sixth grades. During the psychiatric interview she was giggly, silly, showed no sense of responsibility, was unconcerned about her school failures, and told inconsistent and unreliable stories of escapades. It was recommended that she be placed in a girls' training school.

A. H., a white boy, eleven years, nine months of age, physically healthy except for carious teeth, and of dull normal intelligence (mental age 9 years, 6 months; I.Q. 81), was referred because he was implicated in breaking into a warehouse and other buildings, together with six other boys, and stealing cigarettes, raisins, and other small articles. About a month later he was again caught with another boy after breaking into a warehouse and pilfering some wheat, which he sold, buying ice cream with the money.

He was the son of an invalid father and an unkempt, unintelligent mother. Two siblings were in a school for feebleminded children.

A. H. was in the proper grade in school. He spoke truthfully about his misconduct and did not try to shift blame or responsibility. It was advised that he be placed on probation and that he report to the juvenile court at frequent intervals. Social workers made every effort to improve the home conditions, and a year later it was reported that there had been no more misconduct.

C. B., a retarded colored boy of thirteen (mental age 7 years, 2 months; I.Q. 54), was referred because of failure in school, disobedience, roaming about the streets, and petty thievery. His mother, who was away from home all day working as a domestic, wanted him placed in a training school.

His father had died of tuberculosis and his stepfather had deserted nine years previously. Consequently, the boy had been left free to roam the streets and to make petty thefts as the whim moved him. Unfortunately, a boarding home or institution could not be found for such a boy, so it was advised that he continue in school, even though it was not possible for him to progress satisfactorily; that he be given such odd jobs as could be found for him; and that he report to the social worker under a form of probation. A year later there had been no more complaints of misconduct.

G. D., a white boy, thirteen years, six months old, was referred to a social agency by the police because he had several times run away from home and had slept in doorways at night. The last time he had been apprehended he had been much upset, had cried, and had said that he had left home because his mother would not give him all he earned selling papers. The mother complained that he wet the bed and masturbated.

The child was the oldest of four living children of a retarded, complaining, and uncoöperative father and a retarded mother. Two years earlier it had been reported that the mother had been treating the boy harshly, but this was not proved. Obviously, however, there was little opportunity for training in the home, and the boy was, therefore, placed in an urban boarding home, where he began to resume his migratory activities. It was advised then that he be transferred to a rural boarding home where there might be fewer temptations, and that, because of his mental retardation (mental age 9 years, 6 months), he be placed in the fourth grade of the rural school. This was done and the boy made a good adjustment.

A year later he was returned to his parents, became very unhappy, again began to show traits of delinquency, and after four months was again placed in a rural foster home.

The type, frequency, and variety of complaints for which patients were referred to the clinic can best be shown by the following table. It should be kept in mind, of course, that in many cases there were a number of complaints.

Complaint	*Number of patients*		
	Total	White	Colored
Failing in school	176	159	17
Suspected retardation	151	133	18
Nervous	55	52	3
Doesn't concentrate	49	45	4
Asocial	46	44	2
Stealing	35	34	1
Sex problem	32	22	10
Timid or shy	30	29	1
Speech disorder	30	27	3
Temper	29	28	1
Vague bodily complaints	25	24	1
Truancy	24	22	2
Bed-wetting	24	21	3
Queer or odd	23	23	..
Lying	21	19	2
Convulsions	21	15	6
Running away	18	16	2
Suspected psychosis	15	13	2
Motor habits	13	13	..
Masturbation	10	9	1
Daydreaming	9	9	..
Sad or melancholy	9	9	..
Soiling	5	4	1
Disobedience	4	4	..
Fighting	4	4	..
Food fads	3	3	..
Hyperactive	3	3	..
Nail-biting	3	3	..

The following complaints were each mentioned twice: thumb-sucking, exclusion from school, not in school, reading difficulty, cries easily, destructiveness, begging. Sixteen children were referred for advice as to home placement, 5 for advice as to school placement, and 4 for vocational guidance; 2 were referred for examination before adoption.

In the summary outlines, the examining physicians were requested to check in each case the etiological factors, diagnostic findings, and recommendations. These data are tabulated in the three following tables. The figures for the etiological factors and part of the diagnostic findings should be considered to be of suggestive significance rather than an accurate classification.

Etiological factors	*Number of patients* Total	White	Colored
Heredity	108	96	12
Endocrine	7	6	1
Physical	83	78	5
Intellectual	296	255	41
Economic	96	89	7
Family relationships	197	190	7
Social otherwise	91	76	15
No findings	13	13	..
Others	12	12	..
Not stated	5	5	..

Diagnostic findings	*Number of patients* Total	White	Colored
Mental deficiency:			
Degree not given	33	29	4
Idiot	5	3	2
Imbecile	36	26	10
Moron	124	110	14
Border-line	88	80	8
Personality disorder	54	52	2
Simple reactive behavior disorder	74	74	..
Psychoneurosis	17	17	..
Epilepsy	21	14	7
Psychosis	9	9	..
No findings	24	24	..
Others	30	28	2
Not stated	3	3	..

Recommendations	*Number of patients* Total	White	Colored
Institutional care:			
Feebleminded	58	45	13
Correctional	6	6	..
Insane	6	5	1
Orphanage	5	5	..
Boarding home	66	55	11
Change of boarding home	11	11	..
Social treatment	80	78	2
Special class	77	71	6
Vocational training	25	25	..
Tutoring	22	22	..
School transfer	6	6	..
Grade demotion	16	16	..
Grade promotion	2	2	..
Leave school	36	32	4
Advice to teacher	84	79	5
Advice to nurse	6	6	..
Advice to physician	8	8	..
Advice to social worker	81	79	2
Advice to parents	82	81	1
Medical treatment	50	43	7

Recommendations	*Number of patients* Total	White	Colored
Surgical treatment	19	16	3
Dental treatment	25	22	3
Psychiatric treatment	13	13	..
Sterilization	9	7	2

Further physical study of the cases was recommended as follows:

	Number of patients
Medical	72
Surgical	14
Blood	18
Feces	3
X-ray	6
County clinic	26
Others	62

SUMMARY

Since 1934, mental-hygiene clinics have been held in rural Maryland with the coöperation of the Bureau of Child Hygiene of the State Department of Health. Schools, social agencies, and local health departments, which had long felt the need for psychiatric aid, welcomed the clinics and gave them their wholehearted support. The clinics have not only stimulated interest in the prevention and treatment of children's personality and adjustment difficulties, but have also been a factor in the increasing of the state's facilities for the care of handicapped children.

During the first two years, 967 patients were examined in these clinics. In 1936, 63 clinics were held in 19 of the 23 counties of the state, and 469 persons were examined. The results of the examination of many of these patients not only indicate the need for specialized service, but support the view that persons contemplating marriage should be shown by competent physicians to be presumably fit in mind and body to bear and rear healthy children. The advisability of classes for the instruction of young parents is also suggested by these studies.

WE EXAMINE THE MENTAL HOSPITAL

AN EX-PATIENT

A VISITOR to the hospital for mental diseases will be impressed with certain external features which distinguish it from the general hospital. The patient, when he enters, may be even more acutely aware of his surroundings. Very often he arrives with a preconceived notion that if this is not the old-style asylum, then it must more closely resemble the place where his broken leg was mended than any other institution within his experience. In this he is not mistaken, but there is a difference.

The particular hospital of which I write is laid out in a plan that would be highly impractical for a general hospital. It covers acres of land in a spacious, rambling fashion. The main building spreads out in two long front wings, only three stories high, measuring a quarter of a mile from tip to tip. Two shorter wings jut from the rear, forming a triangular pattern enclosing a court. Outside of this area are clustered various cottages, gymnasia, workshops, studios, and greenhouses. Encircling these at a brisk walking distance are the residences of the staff. Overlaid with a pattern of flowered lawns and gardens, tennis courts and gaily colored chairs, the rolling golf links and the distant wood, it is a picturesque scene.

This widespread colony is a self-sustaining unit in unique isolation. It gives an immediate impression of seclusion and permanency, and of being definitely unruffled by the passage of time. The visitor will miss the quiet bustle of the general hospital, the urgent clang of ambulances, the upward flight of elevators, the loud, insistent "Dr. Brown . . . Dr. Brown . . . Dr. Brown . . ." He will miss the public wards, the long rows of beds, the scrubbed, meticulous atmosphere of formaldehyde, the bright, cool bareness, and the desperate urgency of the fight with death. Here there is time, and an infinite patience, a quiet lying in wait for the sickness that hides in the mind, unyielding, month after month.

The average patient enters the hospital with a hazy idea that he will stay a few weeks, or at the most a few months. The examining physician may tell him that no promise can be made as to how long or short a time it will take to cure him. To the patient, this is only slightly more understandable than it is to the patient's relatives. Accustomed as we are to diseases that can be diagnosed after a single examination, this attitude of the hospital seems incomprehensible. We immediately suspect some ulterior motive. In reality, the examining physician has simply stated the truth.

In illness the mind is a double-barred door. When the mental hospital turns its key on the patient, it does no more than he has already done to himself twice over. In some inner recess of his mind, he is hiding, in desperate attempt to escape from the pain of life. In proportion to the greatness of the pain from which he hopes to escape is his dream, his defense, impregnable. The bars on his door may be legion. They may yield in a month, in ten months, in a year, in ten years. They may never yield.

The psychiatrist is at a disadvantage compared with other physicians. He cannot, with a single X-ray plate or one clean sweep of the knife, lay bare the mind. As the general practitioner of centuries ago was compelled to proceed slowly on the accumulated evidence of external signs, even so must he. Every word, every movement, every flicker of expression on the face of his patient is stuff for his test tube. These hold the secrets of illness. He waits, he watches, he listens, and if it would seem as the months go by that he does nothing else, this is untrue.

It is, I believe, an outstanding characteristic of mental nursing that its greatest work is unseen. A visitor might go through the entire hospital in an afternoon and see little upon which he could put his finger and say definitely, "This is how it is done!" In an equivalent time in a general hospital he would be deeply impressed. An appendectomy, a blood transfusion, the setting of a limb, the deflating of a lung—these are activities peculiar to the hospital and visible to the eye. Not so here. Mental hospitals may be said to have few visible tools that are unfamiliar experiences in the average life.

It will seem to the visitor, as he looks about, a somewhat

homelike place, comfortable and dignified, a city home perhaps—where the door is kept locked. He will grow used to the door with time, and will realize that the patients for the most part have grown used to it. If he will talk with them, he will discover that it has become in fact their bulwark against the world. With a few exceptions, they are secretly grateful for protection from themselves. They have lost not only the key to the door, but the key to life. And they know it.

The hospital aims to restore both keys. It says to the patient, "We must go down together into the far corners of the mind and search. In the realm of the spirit every man is his own locksmith. We can give you the tools. We can show you how to use them. You must open for yourself the way out."

This would be impossible for the patient if it were not that his first tool is a piece of life itself. A man who has lost the use of his legs must be taught to walk again by walking. There is no other way. Nor can the patient be expected to meet the situations of normal living if he has no opportunity to meet them. This is the hospital's first problem—to give him as natural an environment as possible within the limits of his illness and his need of protection. Then to observe, to guide, and to reëducate him in his use of that environment.

That is why, when you walk through the hospital, you will see little that will seem to you unhomelike. Wide, carpeted corridors, cheerful individual rooms, spacious lounges, flowers on the tables, the warm glow of floor lamps, a patient reading, a patient sewing, four at bridge, two playing pool, the soft strains of a radio, the distant clicking of a typewriter; the nurse's uniform seems somehow incongruous.

The patient's day is planned with an equal regard for the sustaining of a normal environment. Unless he is very ill, he arises at seven-thirty and retires at nine, with an hour of rest at noon. Immediately after breakfast he sets out, like any normal person, to his "occupation." Here he joins with patients from other halls and cottages in various handcrafts, domestic and commercial arts, or other engagements of his own choice or design. He may work on the grounds or in the library, or assist the nurse on the hall. Whatever he does, he is accompanied and encouraged by trained attendants, as

much or as little as seems advisable in each case. The atmosphere is one of quiet, interested persuasion toward the exercise of his intellectual faculties.

Whatever strain a patient may feel in this work period is relieved by intervals of indoor and outdoor recreation. Or, on the contrary, if he is inclined to stick too close to his work, the daily gymnasium activities will provide the stimulation that he needs. He joins with the group in various indoor and outdoor games—perhaps a trip to the hospital beach house for a picnic or a swim. The long walks through acres of wooded grounds, the quiet hours of sunning on the lawns, the friendly, sympathetic banter of the "physical eds"—all contribute poise of body and mind.

So far we have seen no more than we might have expected—occupation for the mind, recreation for the body—but we have only begun to look about. In any well-organized community the opportunities will extend further—into the social and religious spheres. And so the hospital, which aims to give its patients every possible contact with a world of reality, must include these activities also. Therefore, the teas, the bridge parties, dances, movies, musicals, church services, the library resources, community sings, dramatics, and the beauty parlor.

The effect of the beauty parlor on the mind is tremendous, as any woman knows. To be beautiful and sexually attractive is her natural and normal desire. Denied these expressions, the patient, whether man or woman, will sometimes regress into a state of complete indifference toward and neglect of personal appearance. The beauty parlor and barber shop, the dress-up occasions in which both men and women patients mingle, the brave gesture—whether you feel like it or not—all help to keep up morale.

It cannot be said too often that the psychiatrist is interested not only in the thoughts of his patient; he is interested in the whole man, in his total personality. To the sum of his birth and his bank account, the psychiatrist adds his religion, his golf score, his spelling, his wife, and the state of his tonsils. Nothing can be left out; nothing is left out. If at times stress seems to be laid upon one factor rather than another, it is, I think, because one rather than another has brought the man here.

It seems to me quite natural that physical therapy in a mental hospital is subordinated to its major function. You will notice with perhaps some uneasiness the comparative absence of medical prescriptions, pills, lotions, and the aroma of ether. This is not to say that they do not exist, nor that the patient's day does not include occasional trips to the dentist. In fact, the hospital is completely equipped with dental, medical, surgical, X-ray, and laboratory facilities. It employs a staff of consulting specialists in these fields. Each patient receives complete routine examinations and such treatment as seems imperative. But mental patients are often too disturbed or too easily diverted from convalescence to warrant a surgical intervention or a course of medicine that can be postponed until later. Many of them have notoriously good physical health. In the case of hypochondria, the physician seems justified in withholding drugs once it has been determined that there is no physical basis for the complaint. Mental patients, like most normal people, have occasionally imaginary or self-induced ills.

Behind the scenes there is, however, a great drama of physical attack on mental disease, with definite vital measures, both medical and surgical. It is not the purpose of this article to discuss these procedures, which apply to the occasional and unusual case. But it may be noted that the majority of cases receive some type of dietary treatment, massage, various electric treatments, and hydrotherapy. The uses of water are many. To stimulate the nervous system, the patient is massaged with a strong stream of alternating hot and cold water. If he is disturbed, he is placed in a bath of continuously running water at body temperature. If he becomes violent and in need of restraint, he is wrapped in a warm wet sheet in such a way as to soothe him and prevent him from doing harm to himself or others. These measures frequently replace the use of hypodermics and sedatives. The days of the strait-jacket are gone.

It can readily be seen that these multiple activities of the hospital require an intricate plant, a large staff of specialists in many fields, an enormous outlay of money, and an interesting plan of hospital administration. As the pattern begins to take shape, we are more and more fascinated by the quiet and

ease with which the wheels turn. Groups of patients move in crisscross directions through the grounds, some piloted by nurses, some unattended, each group a separate unit and yet in some hidden way a part of the whole. We begin to sense a definite undercurrent of purposeful activity which has hitherto escaped us.

If there is any magic in this shifting of the scenes, it is the element of planned environment. Most of us have indulged in speculation, at some moment of our lives, on the kind of world we would have made had the chance been ours. The psychiatrist in a mental hospital is in some such omnipotent position. He has enormous power and he wields it for the good or ill of a large body of defenseless people. This is at once the danger and the advantage of treatment in an institution. In incompetent hands, the mind could suffer irreparable damage. It is to the credit of the medical profession that this is so seldom the case.

In skillful hands a planned environment is a healing procedure. It is concerned not only with the general program for all patients, as we have so far outlined it, but with group and individual programs. In studying the location of the halls, we find that, as in other types of hospital, there is a distinct division between the men's and the women's quarters, which are on opposite sides of the building. Each side in turn has three major divisions: the desperately ill and disturbed patients are on back halls, the less acutely ill on front halls, and the convalescent in cottages. Within these units there are still finer classifications. Each hall on the front wing has a character all of its own. Hall 4 is sick and feverish in atmosphere. Hall 5 is young, noisy, and cheerful. Hall 2 is calm and sober.

This system has a distinct advantage over the plan of a general hospital. There a man with an amputated finger may lie in bed next to one who will die, having lost all his limbs. If this makes for efficiency in surgical nursing, it has no such result in mental disease. Though the patient has lost but a finger, the power of suggestion requires that he lose all the rest.

I venture to say that this is the chief problem of mental nursing where a great many sick people are thrown together.

The sick mind is nothing if not inventive. It clings to its individual life with an astounding and apparently inexhaustible succession of symptoms. What it does not think of, the mind next door will think of.

If the mental hospital is to succeed in its work, it must deal with this danger of contagion. There must be careful weeding and classification of patients. There must be temporary isolation wards. But the matter is not so simple as might at first appear. If it is true that the sick affect the convalescent unfavorably, it is equally true that the convalescent nourish and encourage the sick. To attain and sustain in any group just the right balance of personalities is an art that demands the psychiatrist's consummate skill.

This factor, plus the patient's individual requirements, necessitates a frequent moving about which will not be found in a general hospital. To the new patient who is unprepared by previous experience, this may be confusing. He has no sooner accustomed himself to one hall than he is picked up, roots and foliage, and planted in another. There are good reasons for this. He may be going back to a more protected hall, having had a relapse. He may be going forward, being ready for hardier soil. Or, strangely enough, he may simply be getting a jolt to remind him that time is passing him by.

The danger of his becoming too institutionalized is one that the general hospital need not consider, having merely transient patients. The average term of treatment for a recoverable mental case is eight months to a year. It may frequently be longer. During this extended period, the nature of his illness requires that the patient adopt the hospital and be adopted by it, in a parent-child relationship. He places himself not only physically, but mentally under its care. His doctors direct, guide, and advise him in every minute detail of living. If he resents the loss of his liberties, he may not equally resent the loss of his responsibilities. If they were sufficiently burdensome to him, he may even grow to be happy here, and wish to remain ill.

To guard against this, the hospital enlists the aid of intelligent friends and relatives, to keep him in touch with the outside world. He is permitted to write and to receive letters, to have visitors, to share in automobile trips, occasionally to

go to town with a friend for shopping or tea. In the summer, by special arrangement, he may stay with a small group of convalescent patients at the hospital beach house in a neighboring town, where he will have full liberty within the house and grounds, as he has in the hospital cottage. Before he is discharged, it is likely that he will go home for a few week-end trips. If it seems advisable, he may even commute to work for a time while still in residence.

Environment plays such a large part in the treatment of mental disease that the hospital is required to give its attention not only to the patient's immediate adjustment, but also to his future problems. It not infrequently happens that he has made excellent progress, coming up from hall to hall, adjusting himself to increasing freedom and harder situations on each one, and is living a comparatively normal life in the cottages, ready to go home, when he has a relapse. Or he may go home and become ill again in a very short time. In at least some instances it is apparent that this could have been prevented with more understanding and coöperation on the part of relatives or friends.

The mental hospital has, therefore, the peculiarly dual function of preparing the patient for his coming environment while preparing the coming environment for the patient. It recognizes that while it is bending every effort to interpret to the patient the world in which he must live, the world does not have an equal opportunity to understand him. Nor is he easy to understand. It is, moreover, his unfortunate trouble that he least comprehends and is least comprehended by those who are dearest to him.

The attending physician may give many hours of his time to the anxious mother or the troubled husband before they will understand this. The root of the problem lies in the answer to the question why he ever became ill in the first place. Toward the discovery of this kernel of truth, all the activities of the hospital are directed. With it once safely in hand, the doctor's course is clear.

Of this you may be sure: it is none of the things that I think it is or that the patient thinks it is. It is something far more intricate and hidden even from the sick man's conscious thought. And it will take a combination doctor, priest, and

Sherlock Holmes to ferret it out. If this is assigning a very mysterious and dramatic rôle to the modern psychiatrist, he has nothing less. He is the latest of the pioneers in the largely unexplored world of the human mind. And his works speak for him.

The seemingly miraculous cures that frequently occur in the mental hospital are not surprising to these men and women. Day by day, month after month, they have literally lived with their patient, watching and tabulating his every move, arranging and rearranging his life, consulting with one another and with him, bearing the brunt of his complaints, his discouragements, his acute distress, and sometimes his frenzied abuse. When he suddenly takes a turn for the better after months of discouraging symptoms, it is because of the measures that have been patiently and purposely applied and the words that have been persistently reiterated, in an effort to reach his mind.

This function of the physician is the activity that you as visitor do not see, but it is the hub of the patient's treatment. Without it he would be in no better case than he was centuries ago when nature was left to take its course. This is not to imply that the nurses, the physical directors, the occupation attendants, librarians, laboratory and dietetic specialists, the housekeeping personnel, and the whole host of assistant and special workers do not play their vital parts. Indeed without their coöperation the doctor may be thwarted to the point of complete inadequacy. But I do mean to say that, in the final analysis, it is he who locates the lost key to this personality, who goes down into the dark places and discovers what it is all about. He is trained and equipped for this function in a way that we cannot imitate, and this explains why, with all the money in the world and the best of intentions, we cannot cure the patient at home.

You will find that the patient, when he is discharged, will go back to his doctor time and again. He no longer needs the hospital environment. He has learned to stand on his own feet in the fields of the open world. But in the moments of stress that come to us all, he knows who is his friend.

The hospital does not fail him. It gives him the support that he needs until such time as he can do without it com-

pletely. This is done by means of an out-patient service unparalleled in the general hospital. It may amount to occasional interviews over a period of years. It consumes a great deal of the psychiatrist's time, and it costs the patient nothing.

In these days of enlightenment, even for the poor there are doors open. Let me suggest that if you need his help, you take your courage in your hands and trust the psychiatrist. In a hospital of recognized standing, he can be trusted. It is pitiful to read in to-day's paper of a man who, in taking his life, leaves the brief explanation: "I cannot go to a sanitarium."

If he had known what I know, he would have gone.

THE DEVELOPMENT OF PSYCHIATRIC NURSING

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THAT less than 1 per cent of all graduate nurses are concerned with the care of the mentally ill, although this group of patients constitutes more than 50 per cent of all hospitalized patients,[1] may be attributed to five main causes. First, the flexible standards of schools of nursing connected with psychiatric hospitals have not made the work attractive. Second, the attitude of psychiatrists in general toward nursing has prevented the centralization of nursing service in the state hospitals in most of the states. Third, in many psychiatric hospitals the social status of the nurse and her pay are low and the hours of work are long. Fourth, there is a belief, on the part of many nurses, that mental disorders are a disgrace, that patients so afflicted are people to be dreaded, and that the only type of care needed is custodial. And fifth, psychiatric hospitals, under state jurisdiction, provide patronage for politicians, through the positions of attendants.

A study of the 1933 statistics forcibly impresses upon us the great need for nurses in the psychiatric field. These statistics show an astounding prevalence of mental disease. Of the 296,000,000 hospital days in the United States, 173,000,000 were for mental patients.[2] One of every twenty-two persons in this country will develop, at some time in his life, a mental disease of sufficient severity to require hospital treatment. Between 60,000 and 70,000 new cases are admitted to state psychiatric institutions every year, and the population of these is increasing by approximately 14,000 a year. The 300,000 odd patients under care in the state psychiatric insti-

[1] See "The Needs and Opportunities in Psychiatric Nursing," by William C. Menninger, M.D. *Hospitals*, Vol. 11, pp. 43–47, January, 1937.

[2] See *Twentieth Century Psychiatry*, by William A. White, M.D. New York: W. W. Norton and Company, 1936. p. 100.

tutions are maintained and treated at a cost of approximately $200,000,000 per year.[1]

The scarcity of psychiatrically trained nurses is revealed by the figures given on this subject by Mrs. Anne How in 1933.[2] At that time, there were 294,000 registered nurses, 1,870 of whom were in psychiatric nursing. These 1,870 nurses were theoretically responsible for the care of 291,077 mental patients in residence in 166 state and federal hospitals for the mentally ill. The distribution of these nurses is worthy of mention. Seven states maintained hospitals with no graduate nurses, and six states had one nurse each; thus, for thirteen states, representing a patient population of 22,626, there were six graduate nurses, a proportion of one nurse to 3,771 patients. The thirteen states that had the highest number of nurses had a total of 1,640 nurses caring for 136,866 patients, a ratio of one nurse to 83 patients

Mrs. How's report on the amount of instruction given and the experience in the field of psychiatry required by schools of nursing is significant. A course of lectures in nervous and mental diseases was included in the suggested curricula of eighteen states. In sixteen states a period of practical experience was offered in connection with hospitals for mental diseases. Of the 1,802 schools of nursing recognized as meeting the minimum requirements of the National League of Nursing Education, 301 schools in general and psychiatric hospitals reported courses in psychiatric nursing. Psychiatric courses given through affiliation were reported by 130 schools, and 75 schools offered such experience to the few who might choose to take this work. In all, about 506 schools, 50 of which were conducted by psychiatric hospitals, offered some kind of experience in psychiatric nursing. On the other hand, students were being graduated from nearly 1,300 schools without any instruction in the theoretical and practical phases of psychiatric nursing.[3]

In many of the states in which a course of lectures in mental and nervous disease is a requirement for state registration, the subject is looked upon as an unwelcome requirement by

[1] Menninger, *op. cit.*

[2] See "Nursing Needs in the State Hospitals," by Anne How and A. P. Noyes. *American Journal of Nursing*, Vol. 33, pp. 787–98, August, 1933.

[3] *Ibid.*

the schools, and as a result is indifferently taught. Physicians with little experience and not a great deal of interest in the subject may give the lectures. No effort is made to correlate the subject matter of the lectures with nursing practice.[1]

Startling, indeed, are these figures, especially when we consider that more than fifty years have elapsed since the first school of nursing in connection with a mental hospital was established. Yet it has long been recognized that the nurse who has had special preparation in the care of mental illness is more alert to the reactions of all patients. "She has a clearer understanding of the significance of the variations of human behavior and is better qualified, because of her knowledge of human psychology, to give needed help and direction to patients and to their families."[2]

That so few students have been attracted to the psychiatric field has been due largely to the type of school conducted in connection with psychiatric hospitals. "The entrance requirements have been very flexible, almost as flexible as desired by those responsible for their management. Many hospital administrators have believed that an exception should be made for these schools and lower standards required for them than for general-hospital schools of nursing." The age of students on entrance has often been eighteen years or less. This is much too young for those who are to assume responsibilities connected with the care of the mentally ill.[3]

The traditional manner of conducting schools of nursing in these hospitals, states Dr. William A. Bryan, "has been to hire attendants, place them on the wards in positions of responsibility, and give them formal education after their duties as attendants have been fulfilled. There has been little or no separation of education from ward service. Classes for nurses have often been conducted jointly with those for attendants."[4]

[1] See "How the Schools are Meeting This Need [for courses in psychiatric nursing]," by Harriet Bailey. *American Journal of Nursing*, Vol. 28, pp. 505–7, May, 1928.

[2] See "The Preparation of Nurses for Community Service," by Clara Quereau. *The Psychiatric Quarterly*, Vol. 7, pp. 294–307, April, 1933.

[3] Bailey, *op. cit.*

[4] See *Administrative Psychiatry*, by William A. Bryan, M.D. New York: W. W. Norton and Company, 1936. p. 248.

Psychiatric institutions have not taken their responsibilities too seriously, Dr. Bryan continues. "They have purported to train nurses without the necessary clinical material in medicine, surgery, obstetrics, and pediatrics. This has necessitated an affiliating year in a general hospital. Much of the teaching has been done by staff physicians, who have looked upon it as an unpleasant task, a task to be accomplished with the least expenditure of time or energy. Pedagogical techniques have not been good; there has been little expenditure for equipment, and frequently little or no supervision of ward experience." Living quarters have not compared favorably with those provided by general hospitals.[1] "Rarely have there been separate residences for nurses, and more often than not meals have been served in the ward dining room."[2]

"This description does not apply to all the schools. Though all have been bound down more or less by laws and regulations of the state and the hospital superintendents, with little or no authority resting in the hands of the superintendent of nurses, a few have succeeded in climbing far above the rest."[3]

"If adequate nursing care of mental patients is to be provided, the plan of receiving students into the training school through the attendant group is not a safe or a sound one on any but a purely economical basis."[4] "A lack of differentiation between the attendant group and the student-nurse group tends to minimize the type of work that can be rendered by nurses, and when students are paid salaries as attendants, they are not students, but employees."[5] "Often social workers, technicians, and others have been admitted to lectures and clinics, while the graduate or student nurse has remained outside the door waiting the call to present the patient, acting as a guard or an attendant. She has thus been deprived of opportunities she sorely needed."[6]

"In fact, only within the last decade has nursing been considered an important part of the reconstructive and curative work in psychiatric hospitals. And only in very recent years

[1] *Ibid.*

[2] Bailey, *op. cit.*

[3] See "Why Does the Nurse in the General Hospital Need Training for Mental Work?" by Effie Taylor. *Modern Hospital*, Vol. 7, pp. 329–32, October, 1916.

[4] *Ibid.*

[5] Bailey, *op. cit.*

[6] Taylor, *op. cit.*

have those responsible for the medical treatment of mental patients recognized the value of reëducative and reconstructive measures. Together with this recognition, and the advance in medical knowledge as to how best to treat the mentally ill, comes the advance in nursing knowledge as to how to nurse the mentally ill."[1]

That psychiatrists themselves have in many instances opposed the entrance of nurses into the psychiatric field is a well-known fact. This is especially true of physicians who have long been accustomed to the work of attendants, and whose only experience with nurses has perhaps been unfortunate—with nurses of the poorer type, who may have been unsuccessful in other types of work and who have by a process of elimination reached the psychiatric hospital, sometimes on the attendant's payroll. This type of nurse, with no special psychiatric education or experience, has helped to build up a picture of nurses in general. Then, too, there is the doctor-nurse relationship. The attendant is apt to think that she is working for the physician. Nurses long accustomed to working with physicians for a common cause cannot accept this attitude. Furthermore, many psychiatrists are still so imbued with the custodial idea that they think scientific nursing unnecessary. In fact, the attitude of psychiatrists in general toward nursing has prevented the establishment of a centralized control of nursing service in the state hospitals in most of the states. This has greatly hindered the development of nursing in state hospitals.

The social status accorded nurses in the organization of many of the large hospitals for mental diseases has been "slightly below that of clerks, stenographers, and office assistants." This, together with long hours of work and low pay, have kept many nurses away from positions in these hospitals.[2]

The old conception that mental disease carries with it a certain stigma or disgrace, and that this stigma or disgrace is somehow transferred to those who care for the mentally ill, still prevails in the minds of many nurses. There is also the conception that the psychiatric hospital is "a madhouse, a bedlam, a place where patients run around shrieking and shouting, attacking without provocation any one who gets in

[1] *Ibid.*

[2] Bryan, *op. cit.*, p. 81.

their way; that many are tied to beds in strait-jackets"; that there is no such thing as scientific nursing of the mentally ill;[1] that the only type of care needed is custodial; and that "size, strength, and ferocity are the prerequisites for this care."[2]

Dr. William C. Menninger divides the nursing profession into three groups, depending upon their attitude toward psychiatric nursing. First, there are those who have the attitude that psychiatry is something strange, queer, and eccentric, and who view it askance and with a certain amount of fear. They wonder how any one can stand being around these queer people. Second, there are those who believe that experience in this type of work is important and desirable, but who drop it at that. They approve it, but know nothing about it, and do not try to find out anything about it. And third, there is a growing group of nurses with a progressive interest in learning about psychiatric nursing themselves, and in directing nurses under their jurisdiction to an interest in it.[3]

Dr. L. D. Hubbard has suggested that a lack of interest in psychiatric nursing is often due to a lack of intelligent understanding. "Too often a nurse is plunged, inexperienced and unprepared, into the environment of a psychiatric hospital, surrounded on all sides by varying degrees of mental derangement. As a result she develops the attitude that her patients are peculiar creatures, totally incomprehensible, having nothing in common with her, living on a different plane of existence, without human thought or feeling. She cares for them as she is told to do, masking with superficial kindliness a feeling of horror and disgust. She has no true sympathy because she does not understand either herself or her patients."[4]

The rôle of politics in the large public institutions for mental diseases has been an important factor in the prevention of the development of psychiatric nursing more rapidly, in that these

[1] See "The Responsibility of the Psychiatrist to Interesting Nurses in Mental Nursing," by Karl Bowman, M.D. *Proceedings of the Twenty-ninth Annual Convention of the National League of Nursing Education.* Baltimore: Williams and Wilkins Company, 1923.

[2] See "Satisfaction in Mental Nursing," by Nelle Snyder. *Trained Nurse and Hospital Review,* Vol. 78, pp. 371–73, April, 1927.

[3] Menninger, *op. cit.*

[4] See "The Psychiatric Nurse and Her Personal Problems," by L. D. Hubbard, M.D. *Trained Nurse and Hospital Review,* Vol. 82, pp. 616–17, May, 1929.

institutions provide patronage for politicians through the positions of attendants. Mental illness is the only type of illness for the care of which the states have assumed the responsibility, and because of the fact that this disease is so widely prevalent and of so prolonged a nature, large numbers of attendants and very small numbers of nurses are employed, under the guise of economy.

As Dr. Bryan has pointed out,[1] "there is a definite trend toward the discontinuance of the undergraduate schools for nurses as they are conducted in connection with psychiatric hospitals, and toward the substitution of courses for affiliate and postgraduate students from general hospitals. This trend is based on the belief that any specialty must be built on a foundation of general education and experience, and that an educational scheme founded on the specific needs of a particular group of hospitals is not sound."

"To give carefully planned courses will mean the expenditure of considerable more time and money than is now being spent, and no student should receive any salary beyond maintenance. That considerable money has been spent for salaries for students is shown by figures given by Miss Clara Quereau [2] for the state of New York: Student nurses in state hospital schools are paid approximately $350,000 annually. As the maintenance cost of one student is estimated at about $30.00 per month, and the average allowance paid is $60.00 per month, it would be possible to provide for three affiliating students for the amount it now costs to maintain one."

[1] Bryan, *op. cit.*, pp. 250 and 267–8.
[2] Quereau, *op. cit.*, p. 306.

SOME EMOTIONAL PROBLEMS BESETTING THE LIVES OF FOSTER CHILDREN *

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SEVEN years' experience in studying case histories and holding interviews with foster children at the Wichita Child Research Laboratory has disclosed four main sources of difficulty in making the transition from a natural home to a foster home. They are as follows:

First, the natural home, preceding necessity for placement, is usually of such a character that any child living in it would develop acute personality problems. The attitude of happy expectancy directed by would-be foster parents toward a placement child includes the assumption that he will be "just a normal child." Obviously, the personality problem of the child will clash with this attitude of the foster parent. A sense of failure and disappointment will develop on both sides, and further emotional strain for the child will be added to that already engendered by his previous problem.

A second source of emotional strain lies in the wide divergence between the standards the child has been accustomed to meet in the minds of the adults around him and those to which he is asked to conform after placement. Bewilderment and confusion follow a sudden change of standards, especially if conformance is necessary in order that food and shelter may be forthcoming. All too often, the child is left with an unverbalized, but clear belief that the placement, which at first means to him only food and shelter, depends upon his immediate conformity to only half-guessed standards.

A third difficulty is that foster children always feel themselves at a social disadvantage with children who are in natural homes. This sense of disadvantage is compounded of

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emotional responses to several phases of the situation. To understand them, the first necessity is to realize that the status of a foster child is sure to be something to which he will have to adjust himself. In other words, at some time or other, the fact that he actually is a foster child is going to be realized by him as a problem. Wise methods of telling adopted children that they are foster children may postpone this crisis, but only until they start to school, when their status as foster children will become a problem to them. Understanding of this difficulty must begin with the realization that children do not evaluate differences, as adults do, in terms of differences for the worse and differences for the better, but that all differences are for the worse and all set up a feeling of disadvantage in contacts with other children. A rich child living in a poor neighborhood will feel as bitterly set aside and beyond the social pale as a poor child living in a rich neighborhood. If a child, just at the time when he is beginning his important social contacts, realizes that he differs from his companions in so important a matter as his relationship to his family, it is not surprising that he should react to this difference as to something shameful, even though he has previously made a wholesome adjustment. On the heels of his realization usually comes a wonder as to why the parents who bore him denied him this basis of equality with other children. There gradually grows up in his mind a conviction that his parents were in some way unworthy of being parents if they would let this happen. He becomes ashamed of his forbears and bitterly ashamed of himself because he has sprung from such an unworthy type of human being. To be ashamed of one's parent is to be ashamed of one's self, because a parent is part of one's self. If this difficulty arises in the minds of children who have been foster children since infancy, how much more acute must the problem be for the child who leaves his natural home at a more advanced age and who often has direct knowledge that the change has been occasioned by unworthy parental behavior. It is only when we analyze and understand this sensitivity, and therefore respect it deeply, that we can make any headway in helping a foster child to arrive at a wholesome adjustment to this problem and can, thereby, decrease for him an emotional strain which, if unrelieved, may become unendurable with passing years.

The fourth cause of emotional strain for the child who is trying to make the transition from a natural home to a foster home, or indeed from one foster home to another foster home, is the possibility that, after the change, there may be too little of common experience between the two home environments. Adults in the new home often feel that a new personality set-up can best be accomplished by keeping the attention of the child wholly upon his present environment and by helping him to forget as rapidly as possible everything that has gone before. This is not a difficult thing for children to do, and since it seems to be what is expected, they lend themselves willingly to this program of forgetting. Rapid and apparently complete effacement of the past is accepted by foster parents as a condition of adjustment to the present, and they are pleased that the child is not worrying about former events. What is this process really doing to the personality trend of the child? Do not human lives achieve stability and emotional comfort by virtue of a definite thread of continuity of experience and memory? If we could not, at a given moment, remember what our past circumstances were, if there were no one about who could tell us of them or help us to any single item of experience with which to link the past to the present, would we not be much confused? Yet this is the consummation many foster parents wish to bring about for their children, and they congratulate themselves when they feel that they have been successful. The conscious effort to help the child to forget, as quickly as possible, all that has preceded his experience in a foster home is one of the most certain causes of emotional strain and maladjustment.

A study of these four factors shows that they involve conditions which cannot be wholly changed for the child. They are inevitable concomitants of the life situation of foster children and cannot be taken from their experience. What, then, can we do to ease them for him? How can we lessen the strain enough to provide opportunity for the functioning of the natural disposition of the human mind to make a wholesome adjustment to its problems? Helpful steps can be taken as a technique of placement. Initial guidance and education of the foster parents must be used. Direct work with the child on the part of some one with dependable skill and judgment is

necessary if these problems are to be met successfully. Let us consider them in the order presented.

When a child leaves his natural home, investigation reveals that circumstances or personalities in that home have set up unusual personality problems in the child. Foster parents surely have enough to do to adjust themselves and the child to a new relationship without being asked to take upon themselves, immediately, the correction of acute personality problems. A valuable item of placement procedure is to provide every child with a period of temporary, pre-placement boarding care under the supervision of a boarding mother capable of carrying out, under direction, a constructive program of emotional and social reëducation. The expense of this pre-placement boarding-care period is saved to home-finding agencies many times over through an appreciable decrease of replacements.

The difficulties attendant upon a wide divergence of standards between natural and foster homes have been adequately recognized and much help can be given through a placement technique which reduces these differences to a minimum and through counseling foster parents not to expect to make the child over too quickly. A more concrete picture of what the child has actually been accustomed to might be added in some instances. A foster mother may receive direction in the utmost good faith and believe that she understands exactly what the worker means, and yet be so visibly shocked the first time a new foster child comes to the table with dirty hands that he immediately feels there is going to be no pleasing the creature and he might as well run away at once. If the worker had given to the foster mother a very circumstantial account of conditions in the natural home, both mother and child might have been spared unnecessary shocks.

Thirdly, we mentioned the personality difficulties arising from the social insecurity that has its source in the very placement situation itself. This is the most difficult point of all at which to offer help. Each child can accept the fact of placement only according to his ability to adjust to the hard facts of life, just as a crippled child must make his own adjustment to the loss of a leg. Anything we can do to help the foster child make these adjustments to hard reality in a courageous

and sturdy spirit will be of indirect help. It is all we can do. So far as is humanly possible, we can save him from shame for his forbears and for himself as their descendant. Children are eased if they can believe that their natural parents were helpless in the matter of giving them up. If they can be allowed to feel that their parents were rather fine people, they will be further helped. If circumstances make this impossible, as soon as the children are old enough, they should be assisted to realize that the most inept are often helpless and unhappy in the face of their inadequacy. A tolerant attitude toward the parents will sometimes allay bitterness. Habitual drunkenness can be explained as disease, and desertion as an unhappy fear of difficulty. A child will respond, sometimes, to the suggestion that we are responsible only for ourselves, and that the handicap of an unworthy parent must be accepted with sportsmanship as a physical handicap would be.

Lastly, a transition from a natural home to a placement home should be accomplished in such a way as to keep alive, in the mind of the child, his life in his natural home. Foster parents must not only let him talk about his former life, but encourage him to do so. In this way they can discover the nature of his toys, his belongings, and his habits before he came to his foster home. Much experience similar to that in his past can be built into his present life. The next time a foster parent is urged to make life as new as possible for a child, let the urger try to imagine what his own feelings would be to-morrow morning, if he should face a genuinely new life in China, with new clothes and personal belongings about him and new people, who stressed things which had been trivial to him and minimized the things that had loomed large to him, and with no recollection of his former life to help him realize that this changeling creature had existed before and might, therefore, with reasonable certainty look forward to existence to-morrow.

CRIMINALITY IN A GROUP OF MALE PSYCHIATRIC PATIENTS

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WITHIN the last few years the attention of the public has been directed repeatedly to the commission of crimes by persons who show various recognizable forms of psychopathology, who suffer from definite mental disease, or who have a history of commitment to a mental hospital. The questionable responsibility of such offenders, coupled with the frequently grave character of their offenses, renders the entire social problem represented one of immediate and serious consideration both legally and psychiatrically.

But before this problem can be met adequately either legally or medically, there is need for extensive studies of the frequency and the nature of offenses committed by such medico-legal offenders and of the interrelationships existing between crime on the one hand and definite recognizable forms of psychopathology on the other hand.

In an attempt to approach this problem, a general survey was made of all the case histories of male patients in the current files of the Eloise Hospital on the date of November 1, 1934. The general findings may be summarized briefly as follows:

Total case records reviewed		1,394
Case records with insufficient anamnesis		132
Total case records included in this study		1,262
Patients with history of criminality:		
Definite criminality before recognized onset of mental disorder		119
Definite criminality after onset of mental disorder		148
Crime gravely threatened or unsuccessfully attempted:		
Before onset	7	
After onset	49	
		56
Total		323

Patients with history of misdemeanors only	24
Patients with history of conviction for felony	40
Patients with history of house-of-correction sentences for misdemeanors	31

The 132 records that lacked sufficient anamnestic data to warrant inclusion in the study were chiefly records of aged patients and transients whose friends and relatives could not be located by the social-service department.

Of the 1,262 patients included in the study, 323, or 25 per cent, had a definite history of criminalistic behavior, ranging from misdemeanors to felonies. This percentage unquestionably falls short of representing the actual incidence of criminalistic behavior among psychotic patients, for the following reasons:

1. Difficulties inherent in the securing of information often render impossible a complete history of the individual. Frequently, in the nomadic type of patient, a definite criminal history is unknown to relatives and friends, and even to the authorities. In this study, coöperation with the Federal Bureau of Identification, made possible through the routine finger-printing of all admissions to the hospital, was of material assistance in the securing of criminal histories that otherwise would have been unavailable.

2. The routine practice in Michigan, as in many other states, is either to commit directly, or to transfer, to special institutions for the criminal insane all patients with a history of criminality. Hence, the patients in this general mental hospital actually represent a selected group, from which a considerable proportion of criminalistic patients have been removed.

The incidence reported here, therefore, becomes decidedly significant as an indication of the seriousness of some of the problems to be faced in the paroling of patients.

Our findings show also that 119 patients of this group, or 10 per cent of the total group, had actually committed definite crimes before the recognizable onset of their psychosis, and often crimes of a character apparently unrelated to their mental illness, such as embezzlement, swindling, automobile theft, and so forth. In other words, 10 per cent had been crime problems before they became psychiatric problems.

In addition, 148 patients, or approximately 12 per cent of

the total group, were found to have committed definite crimes at or after the recognized onset of their mental illness. Study of the individual case histories, however, indicated that frequently in these cases the offense seemed to be directly related to the existing mental disease—*e.g.*, a homicidal attack motivated by persecutory delusions; hence the problems represented by this group appear to be more psychiatric than criminal. Particularly is this true in regard to suicidal offenses, and the exclusion of this type of behavior reduces the relative size of this group from 12 per cent to 8 per cent. Nevertheless, the fact that 8 per cent of the male patients in a general mental hospital showed definite criminality after the onset of mental disorder constitutes a serious matter for consideration, particularly when the question of parole arises.

Of the 323 patients with criminal histories, 56 were individuals who had gravely threatened or unsuccessfully attempted to commit serious offenses. In this figure are included only those patients in whose cases the attendant circumstances were such that full credence of their threats was warranted. Mere threatening or resentful utterances were disregarded; hence any error in this figure is probably in the direction of understatement.

Only 24 of the patients had a history of crime limited to misdemeanors, for which the penalty was a fine, a reprimand, or a few days in jail.

That 40 of the patients had served time in prison for felony is not in itself remarkable. This figure acquires more significance, however, when it is realized that all these felonies occurred before the recognized onset of the mental disorder, and that these patients were thus serious crime problems before they became psychiatric problems. The same considerations hold true for those patients, 31 in number, who had served time in houses of correction for various types of misdemeanors. Furthermore, a study of individual case histories discloses that the majority of these patients had a history of repeated sentences for both felonies and misdemeanors, over half of the group having served two or more sentences. Briefly, this group of 71 patients, constituting 5 per cent of the total group under study, had established themselves as definite and recognized criminal problems before commitment to a mental hospital had become necessary.

To make possible an evaluation of the various forms of antisocial or criminal behavior represented in one group, the patients were arbitrarily divided into six general categories, as shown in Table 1. Four general types of offense are particularly significant—namely, sexual offenses; homicide, alone or combined with suicidal offenses; physical assault; and miscellaneous felonies. No particular discussion will be attempted of narcotic addiction because of the small number of cases and their essentially psychiatric nature, nor of the minor offenses and misdemeanors because of their relative unimportance as well as low incidence. The question of suicidal behavior also will not be discussed for the reason that it is essentially a psychiatric rather than a legal problem.

The table is as follows:

TABLE 1.—OFFENSES REPRESENTED IN GROUP OF 323 CRIMINALISTIC PATIENTS

		Number of patients	*Percentage of criminal group*	*Percentage of total group*
Sexual offenses		66	20.4	5.2
Homicidal and suicidal offenses:				
Homicidal alone	84			
Suicidal alone	47			
Homicidal combined with suicidal	18			
		149	46.2	11.8
Physical assaults		50	15.5	3.9
Miscellaneous felonies*		28	8.6	2.3
Narcotic addictions		6	1.8	0.4
Minor offenses or misdemeanors:				
Disorderly conduct and drunkenness	16			
Miscellaneous offenses†	8			
		24	7.4	1.9
Total		323	100.0	25.5

* Forgery, embezzlement, robbery, and so forth.
† Vagrancy, non-support, and so forth.

It should be explained that in making up this table patients with a varied criminalistic history were classed according to the offense that had the greatest immediate psychiatric significance for this study. This accounts for there being only 28 patients under "miscellaneous felonies," despite the fact that a total of 40 patients had served time for felonies. Also,

patients with a history of homicidal offenses or physical assault in addition to sexual offenses were included only under "sexual offenses," emphasis being placed upon the type of crime that has given rise to the present public interest in the entire problem.

The term "homicidal offense" was used only for offenses in which the actual intent was to kill. In those instances in which it was difficult to decide between a physical assault and a homicidal attack, the offense was classified as a physical assault. In practically every instance, the homicidal offense had been unsuccessful, since for the most part only those patients who had failed in their homicidal attacks had been sent to this hospital.

Again, in the group of suicidal offenses, only those patients who had made definite attempts to kill themselves were included. Mere threats or suicidal gestures were excluded unless study of the individual social-service history warranted full credence of the threat.

The various items in this table will be discussed in detail later. Here we will call attention merely to certain general considerations. First, there is a definite tendency in this group toward offenses directed against persons rather than against property, contrary to the trend among criminals in general. In the average criminal population, offenses against property usually comprise over 60 per cent of all offenses, while sexual offenses and other offenses against persons range from 10 per cent to 15 per cent each. In our group of psychotic criminals sexual crimes comprised 20 per cent of the total, and other offenses against persons, excluding the suicidal group, amounted to 45 per cent. Hence the generalization is warranted that a disposition toward mental disease may be reflected in an increased tendency toward sexual crimes and other crimes against persons.

In all probability, the trend toward these types of offense in the criminal behavior of persons either already mentally ill or disposed toward mental disorder reflects the inherent tendency of such personalities toward simpler and more primitive responses in the meeting of difficult or strongly emotional situations, the incapacity or lessened capacity for self-control in immediate situations of social conflict, and

lack of the proper integration of intellectual and emotional responses during periods of mental stress.

Another general consideration concerns the extent of criminality found in this patient population as compared with the general population. Unfortunately, no statistics are available as to the incidence of criminalistic behavior in the general population, but it is a reasonably safe assumption that it would fall definitely short of the incidence in this mental-hospital population, a group from which a portion of the criminal element had already been eliminated by legal processes.

In considering possible cause-effect relationships between the mental disorders of these patients and their criminal behavior, an effort has been made to differentiate between offenses committed before and those committed after the onset of the mental disorder. The findings are summarized in Table 2.

TABLE 2.—OFFENSES COMMITTED BEFORE AS COMPARED WITH THOSE COMMITTED AFTER RECOGNIZED ONSET OF MENTAL DISORDER *

	Number of patients	
	Before onset	After onset
Sex offenses	33	33
Homicidal offenses	15	33
Both homicide and suicide attempted	3	9
Physical assault	10	26
Suicidal attempts	6	47
Narcotic addictions	6	0
Miscellaneous felonies	28	0
Misdemeanors only	24	0
Total	119	148

* The 56 cases in which crime was unsuccessfully attempted or merely gravely threatened are not included in this table.

In compiling this table, the individual case histories were carefully studied, and in every instance of doubt, the patient was classified as manifesting criminality after the onset of his mental disorder. It should be stated further that "time of onset" means not the date of commitment, but rather the time at which relatives and friends became aware of serious personality changes in the patient. Often this time of onset antedated the actual commitment by a year or more. It was believed that from the point of view of our study this time of onset was more significant than the more or less chance date of commitment.

In 119 of our group no direct relationship was apparent between incidence of criminal conduct and time of appearance of mental disease. Nevertheless, it is entirely probable that in many of these cases there was a relationship between a developing or incipient mental-disease process, not yet advanced to the point of being recognized, and antisocial behavior.

In regard to criminality occurring after onset, no definite conclusion can be drawn as to cause-effect relationships, since if the suicidal offenses are excluded, the number of patients who manifested criminal conduct before the onset of the mental disorder actually exceeds those who manifested it after, indicating the probability of a concomitance in individuals of two different social problems. To be sure, in a large proportion of the after-onset cases, the criminality appeared to be directly related to psychotic symptomatology, such as persecutory delusions and hallucinations. But on the other hand it must be remembered that fully as large a group in the population of this study suffered from persecutory delusions and hallucinations without manifesting criminalistic behavior. The assumption seems reasonable, therefore, that criminality among mental patients is not due directly to mental disease itself, but that it is dependent upon other factors in the personality. A further corollary of this assumption, which this study in general indicates as reasonable, is that the personality defects that lead to the development of mental disease may also contribute to criminality.

In considering specific items of Table 2, however, a definite difference is to be noted between the types of offense committed before and those committed after the onset of mental disorders. Offenses committed after onset were all of a type directed against persons, while of those committed before onset only about half were of this character. The probable interpretation is that the onset of mental disorder tends to favor not so much the development of criminalistic trends as the manifestation of those trends in certain types of antisocial behavior.

It is of interest also that the number of sexual offenses was the same before and after onset. Despite the relatively small number of cases involved, this constancy, not apparent

in the case of the other offenses, raises the question whether there is any relationship either direct or indirect between mental disorder and sexual delinquency—whether, on the contrary, sexual delinquency does not represent a problem complete in itself, although the existence of a state of mental illness may be conducive to a more frequent manifestation of this offense. We will consider this question further in our discussion of the sexual offenses.

The data on threatened criminality in relation to time of onset are summarized in Table 3.

TABLE 3.—OFFENSES THREATENED BEFORE AS COMPARED WITH THOSE THREATENED AFTER ONSET OF MENTAL DISORDER

	Number of patients	
	Before onset	After onset
Threatened homicide	6	30
Threatened homicide and attemped suicide	1	5
Threatened physical assault	0	14
Total	7	49

Though the group is too small to be of much significance statistically, the findings are suggestive of a direct relationship between mental disorder and seriously threatened crime in which the attendant circumstances warranted the giving of full credence to the threat. Two examples may be cited: one a threatened homicide by a man who locked his family in a room, called an undertaker and stated that he was planning to kill them, and was found by the police using an axe to batter down the door which the family had barricaded against him; and the other a threatened physical assault by a man who pursued a young boy down the street in a rage, menacing him with serious physical harm, and who was overpowered with difficulty by the police before he could catch his intended victim. But the validity of this apparent relationship between threatened criminality and mental disorder is open to question since the study revealed an even larger number of patients who had made equally serious threats, but who had never attempted to put them into action and whose threats had never been taken seriously by those to whom they were made. The general conclusion reached was that the apparent relationship between the threatened criminality and mental disorder was in reality only an indication of the release of

criminal tendencies as a result of the mental disease—that is, that the onset of mental disorder permitted the manifestation of previously controlled antisocial tendencies and that the mental disorder was not in itself the cause of, but merely the agent in the discovery of, previously existing criminalistic trends. Again the assumption seems to be warranted that the criminalistic mental patient really represents two types of social problem, the criminal and the psychiatric, and that the psychiatric aspect serves often only as an agent in the disclosure of the criminal aspects. Hence the conclusion seems justified that the disposition of this type of mental patient calls for extreme care and consideration, with serious weight given to the history of criminal behavior.

Sexual Offenses.—For purposes of comparison, the 66 sexual offenders were divided into those whose sexual offenses involved some manner of actual assault upon another person and those who committed perversions such as bestiality, public masturbation, scopophilia, and homosexuality by mutual consent. There were 41 in the first group and 25 in the second. The 41 were subdivided into those who offended against minors and those who offended against adults. Some of the more significant data with regard to these three groups are presented in tabular form below:

	Against minors		*Against adults*		*Of perversion type*	
	Before onset	After onset	Before onset	After onset	Before onset	After onset
Number of patients committing offense	16	11	7	7	10	15
Hospital admissions:						
First admissions	15	9	7	7	10	10
With two or more admissions	1	2	..	..	..	5
Average age in years:						
At time of admission	35	49	35	44	34	40
At time of study	37	52	39	48	37	45
Average years in hospital	2	3	3	4	3	5
With history of imprisonment	5	0	3	0	1	1

We see from this that 27, or 40 per cent, of the 66 sex criminals had offended against minors, 16, or well over half of them, having committed the offense before the onset of the

mental disorder. The sex perverts make up roughly another 40 per cent of the group, with 25 cases, in 15 of which, again well over half, the offense had been committed after the onset of the mental disorder and hence would seem to have been directly related to it. Only 14, or about 20 per cent, of the entire group had offended against adults.

Of the 16 who had committed offenses against minors before the recognized onset of the mental disorder, 5, or about one-third, had a history of penal servitude, indicating that their criminalistic tendencies had been recognized, but inadequately dealt with. Of the 7 who offended against adults before the onset of the disorder, 3 had a history of imprisonment. That these numbers are too small to serve as the basis for any general conclusions, is readily admitted, but we believe that they do indicate trends of sufficient significance to warrant serious consideration in the development of social measures for dealing with such patients.

Another trend consistently apparent in this entire group of sex offenders is the lower average admission age of those whose offenses were committed before the onset of the mental disease as compared with those who offended after the onset, the difference averaging ten years. This earlier manifestation of delinquency is suggestive of a greater seriousness in the antisocial tendencies of the younger patient, and of the possibility that increasing age and the onset of mental disorder released criminalistic tendencies previously controlled in the older patient.

Another interesting aspect of the problem of sexual offenses is the combination of such offenses with other types of criminality. A summary of our findings on this point is given in Table 4.

TABLE 4.—OTHER TYPES OF CRIME COMMITTED BY SEX OFFENDERS

	Sexual offenders against minors		*Sexual offenders against adults*	
	Before onset	After onset	Before onset	After onset
Actual homicidal offenses	5	2	5	1
Threatened homicide	..	1	..	..
Actual physical assault	2	..	1	..
Miscellaneous felonies	7	..	4	..
Total	14	3	10	1

This table shows that 28 of the 66 patients who had committed sex offenses had a history of other criminal conduct, and that 24 of these, about 36 per cent of the entire group, had shown definite criminality other than sexual before the onset of recognizable mental disorder. In other words, approximately 40 per cent of the sexual offenders had demonstrated criminality in other regards, thereby emphasizing the seriousness of the social problem they represent.

Of further significance is the fact that of the 16 sexual offenders against minors before onset, 14 had offended in other regards. Only 3 of the 11 who had offended sexually against minors after onset had a history of other offenses. Of the 14 offenders against adults, 11 had committed other offenses. It is also of particular interest that of the 25 patients with a history of perversions, none had a history of other types of criminality.

Homicidal and Suicidal Offenses.—The data on the homicidal and suicidal offenders may be summarized as follows:

OFFENSES COMMITTED

	Homicidal		*Homicidal combined with suicidal*		*Suicidal*
	Before onset	After onset	Before onset	After onset	All at or after onset
Total number of cases.....	15	33	3	9	47
Hospital admissions:					
First admissions.	14	31	2	8	44
With two or more admissions	1	2	1	1	3
Average age in years:					
At time of admission.....	44	40	55	50	42
At time of study.....	47	44	57	55	47
With history of imprisonment..	5	..	..	..	..
With history of misdemeanors..	7	1	1	..	3

OFFENSES THREATENED

	Homicidal		*Homicidal combined with suicidal*	
	Before onset	After onset	Before onset	After onset
Total number of cases.....	6	30	1	5
Hospital admissions:				
First admissions.	5	22	1	5
With two or more admissions	1	8	..	..

	Homicidal		*Homicidal combined with suicidal*	
Average age in years:	Before onset	After onset	Before onset	After onset
At time of admission.....	30	41	52	48
At time of study.....	31	45	55	51
With history of imprisonment..	5	..	..	..
With history of misdemeanor...	1	5	1	1

These data show an increased criminality after the onset of mental disorder. No other significant differences are apparent, with the exception of the high incidence of previous prison sentences and previous misdemeanors in the relatively small group of patients with a history of actual homicidal offenses before the onset of the mental disorder, which indicates some social recognition of the problem represented by these patients. There seems to be some differentiation in the average ages for the various groups, but the relatively small number of cases precludes the placing of any validity on these differences. However, in contrast to the sexual offenders against minors and adults before onset there is a sharp difference in average ages, the sexual offenders being decidedly the younger.

Physical Assault Offenses.—The data on the offense of physical assault are as follows:

	Actual physical assault		*Threatened physical assault*
	Before onset	After onset	All after onset
Number of cases.....	10	26	14
Hospital admissions:			
First admission.	9	23	13
With two or more admissions...	1	3	1
Average age in years:			
At time of admission.....	47	38	38
At time of study.....	51	43	42
With history of imprisonment....	1	..	..
With history of misdemeanor.....	8	6	2

This offense appears to differ considerably from those previously considered in that the greater incidence occurs after the onset of the mental disorder, and in that the average admission age was less for those who manifested this behavior

after onset. However, the relatively small number of cases precludes the drawing of definite conclusions.

4. *Miscellaneous Felonies.*—About the 28 patients who committed miscellaneous felonies there is little to be said. All committed the offense before the onset of the mental disorder, and all but two were first admissions. Their average age on admission was thirty-nine years, and their age at the time of the study, forty-two years.

While all of these patients had committed felonies, many of them had been sent directly to the hospital and not to the criminal court. It is worthy of note, however, that of these 28 patients, 12 had actually served one or more terms in prison for previous felonies. One general comment to be made on this group is that their average admission age far exceeds the age of the average criminal offender of this type, and hence that they may represent a different aspect of the crime problem from that represented by the average felon.

Distribution of Psychiatric Diagnostic Types.—Another question concerning these patients has to do with the distribution of psychiatric diagnostic types among them. This is given below, the distribution for the entire group being included for purposes of comparison:

	Percentage of criminal group	*Percentage of entire group*
Schizophrenic reaction types	38	41
Alcoholic psychoses	14	12
Manic-depressive psychoses	12	14
General paresis	10	13
Senile and arteriosclerotic psychoses	7	10
Psychoses with mental deficiency	5	2
Psychopathic personalities	3	2
Epilepsy	3	1
Miscellaneous diagnostic groups	8	5
	100	100

It is apparent that there are essentially no significant differences between the two groups so far as concerns the frequency of occurrence of any particular psychiatric diagnostic type, and that the general distribution of diagnostic types corresponds fairly well with that of other general mental

hospitals. The slight differences may be accounted for wholly on the basis of the relatively small size of the criminalistic group.

In the distribution of psychiatric diagnostic types for the different categories of offense, certain variations in the frequency of diagnostic types were found. These variations only are given here since the general distribution in other respects followed essentially that of the two larger groups:

Of the sexual offenders, 12 per cent had psychoses with mental deficiency as compared with 5 per cent of the criminal group as a whole and 2 per cent of the entire group.

Of the homicidal offenders, 16 per cent had alcoholic psychoses as compared with 14 per cent of the criminal group and 12 per cent of the entire group.

Of the suicidal offenders, 34 per cent had manic-depressive psychoses as compared with 12 per cent of the criminal group and 14 per cent of the entire group.

Of those who combined homicidal with suicidal offenses, 22 per cent were schizophrenic reaction types as compared with 38 per cent of the criminal group and 41 per cent of the entire group; another 22 per cent had manic-depressive psychoses as compared with 12 per cent of the criminal group and 14 per cent of the entire group; and 17 per cent had senile and arteriosclerotic psychoses as compared with 7 per cent of the criminal group and 10 per cent of the entire group.

Of the physical-assault group, 54 per cent were schizophrenic reaction types as compared with 38 per cent of the criminal group and 41 per cent of the entire group.

Of those who committed miscellaneous felonies, 14 per cent had psychoses with mental deficiency as compared with 5 per cent of the criminal group and 2 per cent of the entire group; and 8 per cent had psychopathic personalities as compared with 3 per cent of the criminal group and 2 per cent of the entire group.

Of those who had committed minor offenses and misdemeanors, 34 per cent had alcoholic psychoses as compared with 14 per cent of the criminal group and 12 per cent of the entire group.

No particular comment can be made on these variations other than to say that they are in accord with the general find-

ings in the fields of psychiatry and criminology, and that they possess no special significance for this study.

General Facts of Hospitalization.—The general data on hospitalization for the various types of offender were briefly as follows:

The average percentage of patients with two or more admissions ranged from 10 to 15 in the various groups, with the exception of the homicidal group, in which it was 20 per cent, and the suicidal group, in which it was 2 per cent.

The average age at admission ranged from forty to forty-four except in the case of the sexual offenders who committed their offenses before the onset of the mental disorder, for whom it was thirty-five; the patients who combined homicide with suicide, for whom it was fifty; and the narcotic addicts, for whom it was thirty-five.

The average duration of the period in the hospital was from two to four years, except in the case of the suicidal patients, for whom it was five years.

With the exceptions noted, the findings for each of the various categories of offense were essentially the same. Within the individual groups, as we brought out in discussing them, certain variations in age did occur, but the groups are too small to warrant the drawing of definite conclusions.

One general observation that may be made, however, is that the average age on admission of the criminalistic mental patient far exceeded the average age of twenty to twenty-four years found consistently in the general criminal population. The admission age for the group under study is of course an index rather of the age at the onset of the mental disorder than of the age at the time the crime was committed; nevertheless, it does suggest that the criminality of those predisposed to or actually suffering from mental disease represents a social problem pertaining to a later age level than does criminality in general.

SUMMARY

1. Of 1,262 patients, the male population of Eloise Hospital, a general mental hospital, 323, or 25 per cent, were found to have a history of criminality, despite the general practice of sending mentally disordered criminals to special

institutions for the criminal insane, and despite, further, the difficulties involved in securing complete case histories.

2. A history of definite or actual criminality before the recognizable onset of the mental disorder was found in 119 cases, or 10 per cent of the total population.

3. A history of definite criminality after the onset of the mental disorder was found in 148 cases, or 12 per cent of the total. One-third of these 148, or 47 patients, had committed suicidal offenses, leaving 8 per cent with a history of other criminalistic behavior.

4. Of the 323 criminalistic patients, 56 had a history of having gravely threatened criminal conduct.

5. Only 24 of the group had a history of criminality limited to misdemeanors.

6. In 40 cases a history of prison sentences for felonies was found, and 31 patients had served sentences of varying lengths in houses of correction.

7. Study of the types of offense disclosed a high frequency of sex crimes and of other crimes against persons, the incidence being 20 per cent for the sex crimes and 45 per cent for the others, as compared with 10 to 15 per cent each for the general criminal population.

8. With the exclusion of the suicidal offenses, more crimes were committed before the onset of the mental disorder than after—119 as compared with 101. Of the former, half were directed against persons while all of the latter were directed against persons.

9. The number of sexual crimes committed before and those committed after the onset of mental disease was the same, being 33 in each case.

10. Of these 66 sexual crimes 27 were against minors, 16 having been committed before the onset of mental disease; 25 were in the nature of perversions, 15 having occurred after the onset of mental disorder; 14 were against adults, 7 having been committed before and 7 after the onset of mental disease.

11. Five of the 16 sex offenders against minors before the onset of mental disease, and 3 of the 7 sex offenders against adults before onset had a past history of prison sentences.

12. The average admission age of sex offenders before the onset of the mental disorder was within the fourth decade and

was ten years less than that of similar offenders after the onset.

13. Of the sex offenders, 28 had a history of other criminality. None of these were offenders of the perversion type.

14. More of the homicidal, suicidal, and physical-assault offenses had been committed after the onset of mental disorder than before.

15. There was a high frequency of felonies and misdemeanors among the actual homicidal offenders before onset of mental disease.

16. The homicidal and suicidal offenders were on the average ten years older than the sex offenders.

17. Physical-assault offenses had occurred more frequently after the onset of the mental illness, and the average age of these offenders was thirty-eight years, in contrast to an average of forty-seven years for this type of offender before the onset of mental disease.

18. The distributions of psychiatric diagnostic types were essentially the same for the total hospital group and for the criminalistic group.

19. The distribution of psychiatric diagnostic types for the various classes of offenders showed some variations from the general distribution, but they were not of any particular significance from the point of view of this study.

20. The average percentage of patients with two or more mental-hospital admissions ranged from 10 to 15 per cent for the various groups of offenders, with the exception of the homicidal offenders, for whom it was 20 per cent, and the suicidal offenders, for whom it was 2 per cent.

21. The average age for the criminalistic group ranged from forty years to forty-four years for the various categories except in the case of the sexual offenders, whose offenses were committed before the onset of the mental disorder, and the suicidal and narcotic-addiction groups, the average ages of which were respectively thirty-five years, fifty years, and thirty-five years.

22. The average duration of stay in the hospital up to the date of this study ranged from two to four years for the various subgroups with the exception of the suicidal patients, who averaged five years.

Though the various groups included in the study are too small to serve as a basis for general conclusions, the fact that a history of criminality was found in 25 per cent of this selected group, from which a considerable proportion of criminalistic patients had been removed by legal means, indicates the seriousness of the problem of mental disease combined with criminality.

BOOK REVIEWS

CREATIVE GROUP EDUCATION. By S. R. Slavson. New York: Association Press, 1937. 254 p.

The phenomenon of group activity and group membership is so universal a thing that many lose sight of it entirely when proposing educational procedures. Dr. Slavson, in his excellent work, is keenly aware of the significance to human society of successful group participation. He does not stop there, however. He holds, and rightly, that successful group performance is a measure of personal maturity that cannot be left to chance for its development. What Rugg and Shumaker did a few years ago for the so-called "progressive-school" movement in their *Child Centered School*,[1] the author has attempted to do for club leaders, Y.M.C.A. directors, and others who are faced with the professional task of dealing with the less formal educational programs of such centers. Dr. Slavson would probably deny this and hold, rather, that most, if not all, of his illustrations come from the experiences of youth and their leaders in clubs, centers, and "Y's" because he cannot find good illustrations in school life. In fact, we gather that Dr. Slavson thinks none too highly of group education as it occurs in the typical "school" situation.

The development of the whole personality of the child being properly accepted as the aim of any educational program worthy the name, the author proceeds, in straightforward, convincing style, to show how this process can be achieved in the shifting, growing, moving matrix of group experience. His ideas are not new—in fact, they have a strange familiarity to one who has been reading and working in the field of creative education for any length of time. The value of his work probably lies in the fact that it is written for those who have been too greatly steeped in the traditionalism of club and scout and "Y" leadership, with its competition, its awards, its artificial incentives, and its dependence upon the inculcation, by precept and preachment, of non-existent "character traits."

The opening chapter, entitled, *The Group in Personality Development*, is sociologically sound and perfectly orthodox. Only one unfamiliar with the last twenty-five years of development of a better understanding of the child and the youth, mentally, emotionally, and physically, would consider the material new or startling. But it *is*

[1] *The Child Centered School*, by Harold Rugg and Ann Shumaker. Yonkers, N. Y.: World Book Company, 1928.

genuine and it is well stated. The nature of human emotional maturation, the formation of group status and group loyalties, the counterbalancing of vicious circumstances of growth, are certainly the more important aspects of education, formal and otherwise. The book throughout is full of quotable phrases, such as the one on page 13 in which the author characterizes a good educator thus: "In good education, no preaching of right or wrong should be permitted, and the group educator must refrain from emphasizing shortcomings." As is the case with most such quotable phrases, there is a tendency to overstatement which may lead to difficulties later.

Chapter II is extremely valuable, if for no other reason than that the author has given an excellent treatment of good leadership and its characteristics. Such terms as "alternate assertiveness and withdrawal" and "reciprocal leadership" are fresh and stimulating ways of expressing the relationship between leaders and their groups.

Chapters III and IV, which deal with the school and club program, contain many illustrations drawn from the author's own experience. Determination of individual needs and study of background and experience as a preliminary to the development of creative club activity are given much consideration. The author shows rare insight into the nature of childhood and youth in his descriptions. One is forced again and again to the conviction, "This material is genuine. It happened!" Practically all of Chapter IV is devoted to a summary of the year's activities of a neighborhood club in which the youth had much to do in initiating and carrying forward the work.

The author then, in successive chapters, applies his principles of creative group education to the work of group discussions, arts and crafts, art, music and the dance, dramatics and play-writing, creative writing, the excursion, parties, holiday programs, and gymnasium work.

Extremely realistic is his discussion of the self-governed summer center, in which he describes the variety of opportunities offered for group education in this freer setting.

The qualifications of staff members are certainly not very definitely treated, nor does Dr. Slavson give a very helpful picture of what we suppose to be his idea of an "ideal" educational consultant, although two chapters are devoted to these topics.

One of the most refreshing portions of the book, Chapter XIX, is entitled *Talks with Leaders.* Here, perplexed leaders have brought their problems to the author, and Dr. Slavson has in most admirable manner set forth in dialogue form the clarification of the issues in question. To cite an example, "Mr. E., a leader of a boys' club and an outstanding scoutmaster, was somewhat puzzled by the idea

that education must ally itself with the disposition of the educant [*sic*] and must follow his interests. He has a conventional background and falls back upon 'virtues,' 'pledges,' 'honor,' and so forth in his discussions with boys." He comes to the author and asks how he is to "teach" dependability. Our author become almost Socratic in his procedure. Instead of giving a technique in line with the traditional approach, Dr. Slavson, by skilled and thought-provoking questions, leads the puzzled scoutmaster to a new point of view. Our author concludes his conversation: "You will discover that the very ones who are *taught* honesty, honor, and dependability are those who grow up to be otherwise. Virtues must be a growth; they must be absorbed from the environment."

Another leader is troubled as to how musical taste is to be developed. There follows a practical discussion of how such taste can be developed gradually through participation on the level of comprehension.

One leader, confronted with the well-known tendency of adolescents to be conservative in thought, parroting their elders' ideas, wishes guidance on the problem of developing creative social thinking. As the conversation proceeds, the leader herself begins to see that what she found distasteful was to be normally expected of young adolescents. To grow in power to think, the children must first gain security in their thinking through group approval. Ridicule and "lecturing" must be replaced by the creation of situations wherein the children will see problems of their own and be encouraged to devise solutions appropriate to their age. The forced imposition of adult standards only delays maturation.

Dr. Slavson's discussion of the nature and pitfalls of competition should be read by every coach, club leader, or high-school principal who is tempted to exploit children for the gratification of misapplied adult zeal for "winners" in sports.

And so we might go on. Dr. Slavson is, perhaps unduly, critical of "school" education, and at times indicates a regrettable ignorance of sound creative-school-group practice. On the whole, however, one must admit the seriousness of his charges.

Two appendices devoted to descriptions of actual club or social-center group activities conclude the volume.

The book is marred by its complete lack of documentation. Except for a few inconspicuous footnotes, Dr. Slavson gives no credit to the number of highly able men and women who have for the past twenty or more years done pioneer writing in the field of creative education. One almost wonders if he ever heard of their existence. If he has, it would not have weakened his case to refer to their work. A comparatively uninformed club or "Y" leader, young or

inexperienced in the work, would probably get the idea that our author has discovered something that had escaped the dull notice of other contemporary educators!

But the book is valuable not only for club, scout, and "Y" leaders, but for the general practitioner in education as well. While one may regret the lack of authoritative documentation or recognition of the work of other creative thinkers, the book is documented by its own "cases," which bear the stamp of authenticity throughout. Education for group effectiveness is one of our prime social concerns. Orthodox education is undoubtedly failing in many instances, as is evidenced by adult inabilities and adult infantilisms in group and community, or in political and economic life. Dr. Slavson comes to grips with the problem in the only satisfactory way. He experiments; he knows youth; he has insight into the nature of human action; and, finally, he tells "how it has been done."

M. Ernest Townsend.

New Jersey State Teachers College, Newark.

A Pediatrician in Search of Mental Hygiene. By Bronson Crothers, M.D. New York: The Commonwealth Fund, 1937. 271 p.

The author of this book is "a conventionally trained pediatrician who has become convinced that it is impossible to deal wisely with children handicapped by disorders of the nervous system unless the educational and emotional elements of each situation are carefully considered." The volume claims a tentatively positive answer to the question "whether it may be possible to approach psychiatry, psychology, education, and social service without leaving pediatrics."

About one-third of the book is devoted to a clear statement of the problems inherent in the traditional status of the physician. This is beautifuly done and should be soberly considered by every "mental-hygienist" who is impatient over the failure of the general medical man to seize upon a new and glittering bait. The problem is not new—every institutional structure is conservative and can never conserve anything that it has not tried in the fire of its principles. But there is no denying that Dr. Crothers has done a signal service in using the discussion of a troublesome present-day question nimbly to dissect this age-old problem once more.

Another third of the book lampoons the teaching of mental hygiene in our medical schools and hospitals. It is good reading—that you would expect from Dr. Crothers. You will laugh aloud as he topples the other fellow's dizzy tower of blocks—and angrily blush when he turns to your own. Believe me, this is no book for thin-skinned people. Psychiatrist or pediatrician, if you have not already in true

humility recognized the inadequacies of your own work and insights, avoid this book as you would poison!

Finally, there is a description of the development of Dr. Crothers' unit at the Children's Hospital in Boston. For those who know this remarkable piece of work, the book is a penetrating, honest, and helpful assay. For those who do not know it, the reviewer felt that there should have been a clearer picture of some of the ordinary, common-dirt problems of this venture. That is, it did not seem that this book alone could be an adequate guide in the setting up of another such unit. It seems, moreover, unfortunate that this part of the book was incorporated with the rest. For two hundred pages the author thunders at the complex impracticability of the guidance clinic, and then presents the Children's Hospital scheme as a plausible solution of our difficulties. The fact that to-day in this country there are some four units which might be considered even remotely comparable to his own, whereas there are some hundreds of mental-hygiene clinics, has not been touched upon in this book. Dr. Crothers' set-up may be better than that of the mental-hygienist, but that it is any less expensive, any more possible for the common, garden variety of pediatrician, less full of gear trouble from interlocking disciplines, less cumbersome, more practicable as a widespread educational device—this is not shown. It is our belief that no person in the "guidance" field has so adequately measured the pitfalls in our work as has Dr. Crothers; but we are a bit aghast that he would replace this structure for the pediatrician with something that a bit more subtly involves all of our most difficult problems.

In other words, this analysis of the Boston work is a fine description of a fine piece of work. It should have been lengthened on the "practical-problem" side and put into a separate book. It can well stand on its own feet; it doesn't need the very questionable prop of being an "answer" to the menace of the mental-hygiene movement.

Dr. Crothers irritates, prods, gloriously strengthens, keenly interrogates at every turn. He provokes no less than another book, but since that is impossible, may we stop for just two things?

All through the book runs the thesis that the doctor can go to just that point in the mental-hygiene field at which he still can control and direct proceedings as he does in the physical field. Dr. Crothers forgets that in the matter of *living* the patient is just as experienced—just as much an expert—as is the doctor. He would find it hard going to prove that in the emotional field of human interrelationships the pediatrician or the psychiatrist had made any less of a mess of matters than have his patients. In other words, the problem is not—as Dr. Crothers so skillfully would persuade us to think—the extent to which medicine can maintain its Jehovah posi-

tion in the field of human relationships. It is rather the question whether the physician is willing to give what help he can in the solving of problems that are quite as much his own as they are his patient's. In his first hundred pages, Dr. Crothers shows how really impossible it is for the physician of to-day to step beyond the field of widely accepted knowledge and of that which he can control. The book should logically end there.

A statement on page 183 the reviewer must confess trod upon his own most precious and tender corn. He hears it so often at conclaves of pediatricians and finds its implications penetrating into so many pages of this book that he must respond. We read that Dr. Crothers does not imply the need of any formal or prolonged effort like "attitude therapy" upon parents, but that doctors must recognize that the validity of the advice given depends entirely upon clear understanding by the parents of certain facts and upon correct appraisal of their ability and willingness to coöperate. Dear me! Is this generation to see the tremendous implications of the emotional problems of children, and not see that psychiatrists and pediatricians and parents are as stubborn and blind and caught up in their own needs and failures as the children themselves? One is not necessarily offering a brief for "attitude therapy" in pointing out that the problems of the impinging adults are subtler, more persistent, and again more imperiously overpowering than are those of the child.

Dr. Crothers, with fine caution, would have the pediatrician expand his present domain to cover such of the field of emotional problems as he can with assurance solve *for* the families with which he works. We venture that this is not in the least the problem involved. Rather is it a question as to whether—and how—the physician is to go into the field that involves working on problems *with* his patients. The reviewer ventures that no real emotional problem comes to his office to-day that is not to be found in the world's oldest literature. Nor, to be personal a moment, has the reviewer felt that he was distinctly unusual when he discovered that for himself he wasn't making any tolerably better "answers" than were most of the people whom he knew, or had as patients, or had read about. Authoritative techniques, certain knowledge, the unquestioned word of the expert—if the pediatrician must work with these tools, then he might well stay out of the field of emotional problems despite what this means for the questions and problems that each day come to his office.

Should you read this book?

If—psychiatrist, pediatrician, social worker—you are sensitive, "No." It cuts too well and too deeply into the perplexities that

already confound you. There is not a shy corner of your most persistent doubts that will not be opened to the day's light.

But if you can stand the gaff and if you want a brilliant, challenging picture of an absorbing problem—here it is. Perhaps somewhat without meaning to, Dr. Crothers has managed with a very concrete question to lay before the reader a problem that to-day engrosses the whole Western world. Family, State, Church (just as much as Medicine) face some very new and perplexing issues and threats. On every hand rises the question of this book—whether old techniques and sanctions and tools can be made useful, or whether there must be very fundamental reëvaluations of the relationships between institutions and the people they serve.

Thus, as a "case-history" example of man's most perplexing problem, the book is more than worth your reading. But the answer is no further along.

If you make this "search for mental hygiene," your blood will tingle, you'll chortle, you'll redden, you'll crawl off into the darkest corner, you'll read much of it over and over to drain its last drop of brilliant and searching truth. But, as you finally close its covers, with the veriest little street Arab you will say, "And so, what?"

JAMES S. PLANT.

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STUDIES IN SIBLING RIVALRY. By David M. Levy, M.D. (Research Monographs No. 2.) New York: The American Orthopsychiatric Association, 1937. 96 p.

This monograph consists of two separate studies by Dr. Levy, presented by him at annual meetings of the American Orthopsychiatric Association. The first, and shorter, is an application of a specialized play technique to individual youngsters. In this play a doll susceptible of dismemberment is used as the "mother"; there is a celluloid "baby" doll, and a somewhat larger one for an older sibling (the "self" or patient). The "baby" doll is placed at the "mother" doll's breast and the reactions of the child are watched. These reactions may be stimulated by rather standardized phrases of encouragement.

A series of ten children, ranging from five to thirteen years of age, of good health and intelligence, with problems variously of negativism, inattention, seclusiveness, stealing, and so forth, were studied. The behavior manifested is classified into primitive and modified hostility patterns. Under the former are included direct destruction of all or parts of the various dolls, appropriation by the child of parts, replacement by the "self" doll, and self-destruction. The latter includes modified overt attacks, verbalization of

attack, mothering activities with the baby doll, self-punishment acts, denial, excuses, and so forth. In short, this part of the study is largely devoted to technique and classification of observations into some significance from the point of view of purposeful behavior.

The second paper is concerned with hostility patterns in a series of sibling-rivalry experiments. The subjects consisted of twelve children, three and four years old. Six of these children had difficulties in relation to siblings; six were seemingly adjusted in these relationships, or were only children. The findings are analyzed according to (1) efforts at preventing hostility, by inhibition of initiated movements, refusal to play, and so on; (2) direction of the displayed hostility—*e.g.*, whether aimed at "mother," "baby," or "self" doll, breast, and so on; (3) form of the hostility—*e.g.*, crushing, biting, and so forth; (4) indications of self-punishment and accusation; (5) attempts at undoing of damage (restitution); and (6) self-defending reactions—*e.g.*, blaming examiner, denials, justification, mothering responses, and so on.

It is Dr. Levy's idea that such a play procedure permits the revealing of children's feelings with considerable variability, and yet is standardized enough to satisfy experimental demands; also, that the sequence of events justifies some interpretation of meaning. The following paragraphs may be quoted to indicate the results and interpretation:

> "In play situations constructed to release the feelings of children in a sibling rivalry experience, essentially similar patterns of activity appear that represent dynamic principles of behavior. The child's response to the mother-baby combination, when hostile, is felt chiefly as an urge to destroy, by immediate primitive release of feeling in the form of biting, crushing, and tearing. Checks to this impulse are already manifest at the three- and four-year levels. They operate typically in the initial phase of the act, either blocking it or allowing only its partial release. Once hostile behavior is set in motion, it runs a well-defined course, felt by the child as a 'push' or 'compulsion' to act—along the prescribed lines of the pattern. Following the release of hostile feelings through an attack on the object, the child must pursue one of three kinds of self-redeeming behavior, of necessity, all three, if the hostility is to go on. They consist of self-punishment, equal in amount to the hostility displayed; of attempts to make good the damage done, by restoring the objects to the pre-bellum stage; and of various defensive measures—lies, evasions, and justifications. As the full pattern unfolds, the child may resist at any point, anticipating and protesting the next move.
>
> "Checks to action are evidently derived out of fear of consequences, felt as a fear of the destructive impulse. Clearly, also, the 'self-redeeming' behavior acts to allay the anxiety rising out of the destructive act, and enables further hostility to go on.
>
> "The completion of such patterns of behavior, observed in gradient or cyclical forms, affects the child's behavior toward the object of

rivalry in a beneficial way, presumably by reducing feelings of hostility, thereby allowing the growth of other forms of response."

Quite detailed case records of the experiments are included, as well as graphic representation of the hostility patterns, prevention of movements, and self-punishing behavior.

The study certainly is a splendidly formulated attempt by one of the pioneers in individual play therapy. That it maximizes observation and minimizes interpretation is almost as certain; to a considerable extent the behavior seems to speak for itself. That where additional interpretation occurs, it is in line with the pretty generally accepted principle of purposiveness of behavior, is a stressed point.

Without any spirit of criticism of work that has been so ably done, one may yet present some of the questions that occur to one: 1. What would these children do without any helping hands in initiating reactions? 2. How much is inevitably suggested by the described doll-family set up—suggestion that may do more than simply uncover or free responses already there, that may actually determine them? 3. How many children without overt problems would fall into similar classifications under similar procedures? After all, any child has either to attack or to inhibit. Dr. Levy to an extent indicates this in his rather close correlation of extent of attack with actual family situation.

The study is not simple reading, but it is worth the time of any technician in behavior work to study it carefully. To the reviewer it has not only presented well actual procedures and results, but it has also pointed out that course so difficult to steer between experimental validity and interpretative airiness.

FORREST N. ANDERSON.

Child Guidance Clinic of Los Angeles and Pasadena.

PERSONALITY DEVELOPMENT IN CHILDREN. By Ernest J. Chave. Chicago: The University of Chicago Press, 1937. 348 p.

The real merit of this book, whose author is associate professor of religious education in the Divinity School of the University of Chicago, lies in its multiple approach to the problem of character development. The native equipment of the child, physical, emotional, and intellectual, receives proper attention. Justice is done to the fundamental assets as well as to the potential liabilities inherent in the organismic foundations of the person. Moreover, the author never loses sight of the fact that no human organism grows in a vacuum. Five chapters, therefore, are devoted to a presentation of the environmental conditioning factors. There are also chapters on the handi-

capped and the maladjusted child as well as a chapter on methods of studying personality and one on community coöperation.

The author fully appreciates that "the secrets of guiding personality development are not in general principles which deal with 'averages,' but with delicate adjustments, tactful suggestions, and trustful patience. A small difference in a meaningful moment may cause a distinct shift in conduct, favorable or otherwise." This we conceive to be a sound psychobiological viewpoint. And it quite naturally grows out of the author's concept "that personality is the product of three interacting forces—heredity, environment, and the growing self."

If there be weak chapters in the book, they are those entitled *Growth in Moral Discrimination* and *Significance of Religion*. The reviewer would question any chapter on "morals" that judges behavior "to be good or bad according to the prevailing standards of those interested" in it. Such a concept is based on the *mores* prevalent at any given time and tends to make *mores* and morals synonymous terms. This is a sociological concept of philosophy in that it makes morality nothing more than the highest rationalization of local cultural values. No place is found in such a concept either for the natural law or for God's positive law; hence no *principles* of conduct can be formulated. The result is much talk of what might be termed the brotherhood of man without any real recognition that that is but an empty phrase unless the Fatherhood of God is posited as fundamental and essential. No such concepts as those formulated by the author do justice to man's rational nature. We are, of course, in complete sympathy with the need to take all factors—constitutional make-up, training, and the present situation—into account in judging the morality of any particular person's acts at any given time.

The book is addressed to educators and parents interested in the personality development of the child. Undoubtedly, for such there is much in it which can be read with real profit. The index is quite adequate.

HENRY C. SCHUMACHER.

Cleveland Child Guidance Clinic.

FEEDING BEHAVIOR OF INFANTS; A PEDIATRIC APPROACH TO THE MENTAL HYGIENE OF EARLY LIFE. By Arnold Gesell, M.D., and Frances L. Ilg., M.D. Philadelphia: J. B. Lippincott Company, 1937. 201 p.

This monograph is an attempt at delineating the successive stages in the early development of the eating process. As in other studies

from the Yale Laboratory, cinema records taken at successive stages of development form the chief source of data. The period covered extends from birth to two years of age, by which time the average child has acquired some degree of skill in the art of feeding himself with a spoon.

The book is divided into three parts and an appendix. Part I, entitled *The Behavior Aspects of Nutrition,* includes five chapters, including a discussion of the concepts of infant feeding, a good normative summary of behavior development, an account of the motor mechanisms involved in feeding, and a very interesting historical description of primitive devices for the artificial feeding of infants.

Part II, *The Growth of Feeding Behavior,* gives a profusely illustrated account of the developmental changes in the child's reactions to the breast or bottle, cup, and spoon. The authors state that this material is to be looked upon as normative data with which the progress of individual infants may be compared.

Part III, *The Regulation of Feeding Behavior,* is concerned for the most part with questions of infant training. The chapter on feeding schedules makes a strong plea for flexibility of schedules, without foolish indulgence of the child's whims. It is pointed out that children differ in feeding requirements, and that the same child will vary somewhat in his demands from day to day. Organic needs should hold sway over a clock-regulated system. In Chapter XI, some special problems related to feeding, such as thumb-sucking, weaning from breast or bottle, and training for bladder and bowel control, are considered. There is also an interesting chapter on the adult-infant relationship.

The appendix is devoted to a series of illustrated case histories on the development of feeding and associated behaviors in each of four infants. There is a blibliography of 68 titles and an index. The book is copiously illustrated with half-tone reproductions of actual photographs.

FLORENCE L. GOODENOUGH.

University of Minnesota, Minneapolis.

PSYCHOLOGY OF PERSONALITY AND SOCIAL ADJUSTMENT. By Robert Leeper. Mount Vernon, Iowa: Cornell College, 1937. 61 p.

This is a "handbook" made up of scattered materials relating to the topics of personality and social adjustment. Its emphasis is on the normal or "near-normal" personality, rather than on the abnormal, so frequently stressed in textbooks dealing with personality problems. It is a scientific treatment of the subject and thus fills the need of supplying students with material not too popular in form.

The material is well organized under various topic headings, such as, *How to Deal With Others in Ordinary Social Contacts, How to Handle Mild Personality Defects of One's Own, The Main Types of Learning That Underlie Personality Development,* and so on. This material has, for the most part, been drawn from other textbooks and is illustrated throughout, thus giving it a unity often lacking in books of this sort.

The author suggests that the book may be used as a textbook for beginners in psychology. He himself uses it in his first-semester psychology classes, preceding general psychology. I personally question the wisdom of this. The material is, on the whole, too technical to be readily understandable without some background of psychological fundamentals. Even if students could cope with it, it would be more meaningful if used later.

At the end of each section there are splendid suggestions for "projects" for independent work and thought on the part of the student. These are especially good because they give the student an opportunity to apply what he has just studied to his own experiences. For example, one of the projects listed under Topic III, *Motivations,* is that the student "skip a noon meal" and then analyze his reactions in the afternoon, "to see what light your experience throws on the abstract principles regarding motivations."

A very good list of references is given at the end of each topic, covering the main points just discussed or designed to supplement them. A brief analysis is made of the high points of each book recommended, so that the student will have a general idea of what is in it. The only difficulty with giving so varied a list of books for reference is the practical problem of supplying all of these books, especially in a small college library.

Splendid suggestions regarding personality development, combined with illustrations taken from everyday life and literature, make the book more alive and stimulating than the general run of books of this sort. The constant emphasis on the normal, rather than the abnormal, aspect of personality, gives the student a more wholesome point of view than if the emphasis were the other way around. The book, therefore, fills a real need in the field of psychological textbooks.

ELIZABETH B. HURLOCK.

Columbia University.

CONTROLLING HUMAN BEHAVIOR; A FIRST BOOK FOR COLLEGE STUDENTS. By Daniel Starch, Hazel M. Stanton, and Wilhelmine Koerth. New York: The Macmillan Company, 1937. 638 p.

This book breaks away from the conventional form of the textbook on general psychology and, in the words of the authors, "aims to

bring together psychology and living." It is a splendid example of how psychological principles can be tied up with everyday life. Thus, it shows the student who is beginning psychology that this is not an abstract study, limited to classroom and laboratory, but rather one that will help him to understand people and, in turn, adjust himself more adequately to life situations, whether they be in the classroom, the home, the business office, or elsewhere.

"Life," according to the authors, "may be divided into two parts: guiding your own behavior, and guiding the behavior of others." They have taken this principle as the basis of their division of the material of the textbook. Part I deals with the general topic of "Controlling the Behavior of Self," and Part II with "Controlling the Behavior of Others." In these two subdivisions, the authors have managed to include nearly all the important data one generally finds in a textbook on general psychology, in addition to material from applied psychology.

The book differs from the typical general-psychology textbook in two outstanding respects. In the first place, very little space is devoted to a discussion of the nervous system and the various sense organs, with their accompanying sensations, topics that, for the most part, receive too much attention in introductory texts. What space is devoted to them is justified by tying them up with behavior, an association that most writers assume the students will make for themselves. In the second place, this text is distinctive in presenting its material in a practical form, showing its application to life situations; we find, for example, a discussion of "fatigue in the school" rather than an abstract discussion of fatigue and its most common effects upon the individual.

Part I gives a comprehensive survey of the most important topics found in a textbook on general psychology, such as the dominant human urges, habits, learning, thinking, remembering, feelings and emotions, and so forth. In each instance, the authors have discussed the material from the point of view of the control of these forms of behavior by the individual, in addition to presenting information as to what they are.

In Part II, the authors have given a comprehensive summary of material similar to that found in a textbook on applied psychology. They discuss such problems as the control of the behavior of children in school and in the home, the control of behavior through advertising, personal selling, public speaking, religion, art, music, and entertainment. All of these topics are treated in a very lively, interesting manner.

While the book on the whole is a splendid, comprehensive treatment of the fundamental principles of psychology as applied to living,

three minor criticisms may be raised in regard to it. In the first place, the book is so comprehensive in scope and so long that it could be used only for courses that run throughout the entire academic year, and even then it would allow the students little time for supplementary reading. In the second place, the list of questions given at the end of each chapter are too brief to cover the material of the chapter. It would be better either to omit these questions entirely or to make them a more important part of the text. And in the third place, the copious references at the end of each chapter are not marked in any way to enable the student to know which are likely to be the most helpful and understandable to him. This is an especially serious omission when instructors require reports based on certain topics for which the student must do collateral reading.

These shortcomings are, however, of minor importance, and in no serious way detract from the excellence of the book.

ELIZABETH B. HURLOCK.

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ALCOHOL: ONE MAN'S MEAT— By Edward A. Strecker, M.D., and Francis T. Chambers, Jr. New York: The Macmillan Company, 1937. 230 p.

The title of this book immediately suggests an unusual approach to the problem of alcoholism. The book is divided into two parts, the first dealing with the psychology of alcoholism and the second with its treatment. The pharmacology of the drug alcohol is clearly described, but careful attention is given as well to the qualities of the underlying personality. The type of individual who is unable to profit by treatment is obviously the immature person whom we have come to look upon as the psychopathic inferior. The normal drinker is defined as one who controls his use of alcohol and uses it because he finds that by means of it he can relax more easily and can enhance the enjoyable qualities of reality. The alcoholic is one whose drinking has become a problem to his friends, his family, and to himself, and who has a growing tendency to use alcohol for its psychological compensatory power, as an escape from, rather than an enhancement of, reality. The alcoholic is said to have a psychic allergy to alcohol, and the authors do not mince words in stating emphatically that such an individual should never drink. At this point the quotation, "One man's meat is another man's poison," is very happily placed. Standards are set forth by which one may judge whether alcohol is being used safely and sanely, but the writers state that there is no absolute rule to cover all cases.

They have found that 90 per cent of all abnormal drinkers are of the introverted type of personality, and the impulse that causes them

to drink is partly a desire to extravert and socialize themselves. These individuals also enjoy the compensating phantasies that are associated with the use of alcohol. "Truly, alcohol burns well in the Aladdin Lamp of Phantasy."

The relationship between alcoholism and emotional instability is stressed, and there is a discussion of the dynamics of the alcoholic psychoneurosis. A case history is presented in detail to show the way in which the escape mechanism is utilized. The various other faulty mental mechanisms are discussed also, with particular emphasis on rationalization. The alcoholic breakdown is described, as well as the typical state of the problem drinker who is incapacitated and in need of help.

In the treatment of alcoholism, a high goal is set: the authors believe that the successful therapist should have an absolute conviction that he can bring about such a state of mind in his patients that they will never desire to drink again. Response to treatment is defined as a climbing to higher and more mature emotional levels. At the very outset the authors' answer to the question, "Can I learn to drink in moderation?" is emphatically, "No." Here they are in agreement with all sound students in this field of work. The majority of patients should have at least a month away from their usual environment. The protection of a hospital during the early stages of the treatment is not compulsory, and patients are given an opportunity to attempt the treatment without hospitalization. The family's point of view is given careful consideration. The attitude of a family long exposed to the trials of living with an alcoholic must be modified, if the best results are to be secured.

In the first interview, it should be ascertained whether or not the individual looks upon himself as an alcoholic. The patient is given some idea of the physical effects and dangers of alcohol, and is asked to undertake a personal study of himself, combined with suggested readings. Relaxation finds a place in this type of therapy.

The writers describe the method by which a psychologically curative conditioned reflex is established. They recommend approximately one hundred hours over a period of a year. The first three months of treatment should comprise three appointments a week, after which, if progress is favorable, the appointments may be decreased to two a week. Formulæ in the form of suggestion therapy are described and vocational readjustment is recommended in certain instances. "Obviously, the broker's office is not the place for a highly introverted personality with literary ability, nor is the stock exchange a good field of endeavor for a man whose readjustment will depend much upon his ability to face reality in all its phases." Patients are cautioned

against becoming overfatigued. The points of treatment and reëducation are summarized in a useful fashion for the reader.

There is an additional chapter on the physiological and nutritional factors in alcoholism. The statement is made that, per drink, the alcoholic is suffering greater concentration in the tissues of the body for longer periods of time than is the case with the occasional drinker. In a discussion of the effect of alcohol on sugar metabolism, we learn how the alcoholic's habits are reflected in his metabolism. In the progress of reconstruction, dietary measures play a rôle.

The book is very readable, and can be easily understood by the layman. It does not reveal as much interest in some of the deeper roots of the problem as has been shown by others, nor is our attention too much taken up with end pictures. The setting in which the difficulty develops is dwelt upon, and the ways in which the gradual and progressive maladjustments take place are brought to our attention. The book should be helpful to the troubled layman, the practitioner, and the psychiatric student in this particular field.

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SHADOW ON THE LAND: SYPHILIS. By Thomas Parran, M.D. New York: Reynal and Hitchcock, 1937. 309 p.

The shadow on the land with which this work deals is by no means a new shadow. Civilization is endeavoring to catch up with it as it passes over the American scene, moving with the new light shining upon the subject of syphilis.

As a bit of propaganda to promote a rational syphilis-control program on a national scale, Dr. Parran, Surgeon-General of the United States Public Health Service, offers here a clear, scientific statement of the nature and meaning of syphilis. In no uncertain language, he sums up the results of syphilis upon national health. Indicating the deep responsibility of public-health officers, he sets forth the general problems involved in and related to syphilis, which has been more detrimental to human welfare than any other single disease, not excepting tuberculosis.

A generally hopeful tone pervades the volume, which emphasizes the need of complete medical care, including diagnostic tests and continued therapeusis. Stressing the harm to individuals and to society that results from a lack of medical attention, Dr. Parran reviews the baneful effects of syphilis at every age and under varying conditions. There is evidence that syphilis is several hundred percent more frequent in the United States than in Great Britain,

although it would be possible to reduce the incidence to the very low rate that has been attained in Sweden by an intelligent application of existing knowledge and organized public control.

It is interesting to note that, with the strong emphasis upon treatment, there is a very limited discussion of the broad problems of prophylaxis. Perhaps the reason for this is to be found in Dr. Parran's estimate that "half of all syphilis infections have been acquired innocently."

The work reveals what is already well known concerning past and still potent taboos against venereal diseases in general and syphilis in particular. The degree to which fears concerning sex and hypocrisy with regard to venery have operated to increase personal inadequacy, through feelings of shame, guilt, humiliation, and despair, is beyond calculation. No Social Security Act could be more significant to mental health than the social security that would follow from the prevention and control of this protean destroyer.

The fact that neurosyphilis, including paresis and cerebrospinal syphilis, is responsible for 10 per cent of the first admissions to our hospitals for mental disease, bears testimony to specific neural destruction. If to this one adds the secondary mental deteriorations arising from apoplexy, arteriosclerosis, heart disease, and general visceral disorganization due to syphilis, the mental-hygienist is forced to become almost a zealot in this campaign for the control of the syphilitic person, because only thus can the disease be conquered. The treponema may be the infective agent, but the treponema-carrier offers the main problem to be solved.

Mental hygiene has a definite part to play in the prevention of exposure to venereal disease, in the meeting of infection when it is acquired, and in the encouragement of rational treatment, to the end that life, and not death, may be the goal of rational living. Dr. Parran's book is most useful as a literary instrument for public enlightenment. If his message is understood and his ideas followed through, mental health will be protected and public efficiency enhanced.

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THE PRINCIPLES AND PRACTICE OF CLINICAL PSYCHIATRY. By Morris Braude, M.D. Philadelphia: P. Blakiston's Son and Company, 1937. 360 p.

This textbook of psychiatry gives in terse outline the data of clinical psychiatry. The viewpoint appears on the whole to be

Kraepelinian, but the author appends a final chapter on psychoanalysis.

The arrangement of each chapter—with subject headings concerning the historical survey, definition of the disease, incidence, classifications, etiology (predisposing, precipitating), pathogenesis, morbid anatomy, symptomatology, diagnosis, differential diagnosis, prognosis, and treatment—makes for easy access to the material.

The case histories could be more condensed, the short excerpts from the physicians' and nurses' notes serving no useful purpose.

This is a practical book, and in its effort to stimulate interest, it suffers from that over-systematization which was the great sin of the Kraepelin school. In a small book, it may be necessary to condense, but this may lead to a stunting of the natural inquisitiveness of the students of to-day who are to be the pioneers of to-morrow.

For a small textbook, considerable space is devoted to medico-legal issues, reflecting perhaps the milieu in which it arises.

The classification follows more or less closely that recommended by the American Psychiatric Association. The distinctions, now somewhat thin, between psychoneuroses and psychoses are upheld. The differential-diagnostic problems are at times rather far-fetched and add little to the discussion. Too much concern for the "either-or" has been the bane of psychiatric nosological thought.

The book makes no contribution to the need for a psychiatry of action, starting anew, unfettered by the preconceptions of the past. It will doubtless serve some useful purpose in situations where the comforts of academic nosology (serviceable as they have been) are preferred to the vicissitudes of uncertainty.

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NOTES AND COMMENTS

Compiled by

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The National Committee for Mental Hygiene

TWO MENTAL-HYGIENE ANNIVERSARIES

When, on May 6, 1908, a handful of men and women met in New Haven to found the Connecticut Society for Mental Hygiene, "as a challenge to the social attitudes which had controlled the thought and action of mankind toward the insane from time immemorial," little did they realize that the seed they planted would, within a year, flower into a national movement and, in a decade, spread its growth beyond the country's borders. They builded better than they knew, for such was the life-giving force of an idea germinated in the mind of a former mental patient and brought forth on that spring day for all the world to cultivate and make its own.

What has happened to this movement since then was reviewed by eminent leaders in the United States and Canada on two occasions—when the Connecticut Society and the National Committee for Mental Hygiene of Canada celebrated their thirtieth and twentieth anniversaries, respectively, in New Haven and Montreal, on May 5–7 and March 21.

At New Haven the program began with a Founders' Dinner; continued through a two-day institute of mental hygiene for social workers, teachers, public-health nurses, and other professional workers; and ended with a mass meeting, at which the speakers were His Excellency, Governor Wilbur L. Cross, Dr. C.-E. A. Winslow, Professor of Public Health at Yale and President of the Connecticut Society, Dr. Clarence M. Hincks, General Director of The National Committee for Mental Hygiene and General Director of the Canadian Committee, the Rev. Dr. Anson Phelps Stokes, Canon of Washington Cathedral, and Clifford W. Beers, founder of the mental-hygiene movement.

At Montreal the Canadian Committee held a public meeting under the chairmanship of Sir Edward Beatty, Chancellor of McGill University and President of the Canadian Committee, which was addressed by His Excellency, The Right Honorable Lord Tweedsmuir, Governor-General of Canada and Patron of the Canadian Committee, and Dr. Livingston Farrand, former President of Cornell University.

While mental hygiene has been and still is seriously concerned with the great problem of mental disease and mental defect, it has long

since emerged, as Sir Edward Beatty pointed out, from exclusive preoccupation with the care and treatment of the insane and feebleminded to a broad field of endeavor wherein "robust, healthy, satisfying, and effective living on the part of all citizens constitutes the objective."

Elaborating this thought, Dr. Winslow said that mental health is a problem that concerns everybody, and that the handicaps that morbid emotions in so-called normal people place upon the shoulders of society "outweigh in their total the cost of all the mental hospitals in the world."

The important thing, according to Dr. Farrand, is the prevention of mental and emotional disorders and "those minor phases of mental abnormality which cause so much difficulty to the civic body and to mankind." He viewed "with the greatest enthusiasm" the emphasis that is being placed on child guidance. "It is here, I think, that we must look for the greatest advance," he concluded.

Similarly, Dr. Winslow looked to the school classroom as the place where "upbuilding of a complete and healthy personality shall be a major objective and not a place where mental disease in the form of fear and insecurity or wounded pride and revolt or too aggressive competitive personality is cultivated as in a hotbed of emotional contagion."

Dr. Farrand characterized mental disease as one of the two great enemies—the other being venereal disease—which have not been attacked with the proper energy and determination by the public-health movement, and urged that governments and official health departments take on greater responsibility for the protection of mental health as a vital aspect of the public-health problem. One of the greatest needs in this connection, he added, is the production of adequate expert personnel to deal with the problem.

Speaking of the importance of research, Lord Tweedsmuir remarked that a mental-hygiene committee, through its surveys and studies, has a valuable function to perform in searching out and suppressing the charlatan. "At the commencement of a new study," he said, "there is a magnificent chance for the quack, and there can be no task of greater public importance than to protect the sufferer against the cruelty of false hopes and bogus remedies."

The Founders' Dinner at New Haven was held at the Faculty Club, formerly the home of Canon Stokes, then Secretary of Yale University, in which the Connecticut Society for Mental Hygiene was founded. Dr. Stokes, one of the original group of fourteen founders, traced the dramatic origin of the society, recalling the events leading up to that historic day when Clifford Beers presented his well-laid and far-visioned plans for the reform of institutions for the insane

and the campaign against the scourge of mental disease. In his vivid re-creation of the early scenes of the mental-hygiene story, he contrasted the rise of the movement with other movements for human welfare, pointing out five conditions regarded as "generally necessary for the successful starting of any important social reform"—namely, a great social need, an arresting and authoritative appeal, a forceful leader, an effective plan of work, and a strong body of coöperating supporters. These are usually supplied by different men, he said, but in the case of mental hygiene, four of these were "all due to one man, Clifford Beers," while his book contributed largely to making the social need known. "I am simply amazed," Dr. Stokes said, "as I see how this young man, then thirty-two years of age, organized a local and national movement, and later an international one, of such significance and wisdom that it has been copied in almost all civilized nations. Nothing would down him. He was a born optimist and an unflagging worker—a super-salesman of a philanthropic ideal."

International Notes

AUSTRALIA

New South Wales

The Council for Mental Hygiene for New South Wales was founded in Sydney in 1932. The activities of the council have been carried on mainly through three subcommittees which were appointed to deal especially with three topics—namely, criminality and delinquency, mental deficiency, and child guidance.

Special attention has been given to the need for legislation looking to psychiatric provisions for subnormal criminals and delinquents, and a bill has been drafted for submission to the government. This bill provides for the thorough examination by two qualified physicians of any prisoner who has, on two occasions, been convicted of certain scheduled offenses and who is believed to be mentally deficient. If the examiners report that the prisoner is mentally defective, he is then brought before a magistrate who, if he be of the like opinion, will make an order for his detention in an institution for mental defectives.

The council is also considering the introduction of more up-to-date legislation dealing with the mentally deficient in general. The need, in this connection, is for special provisions for subnormal children who cannot profit by ordinary instruction, and for social care and supervision of adolescent and adult defectives who are otherwise likely to drift into the ranks of criminals and the unemployables. The need for more reliable statistics regarding the incidence of mental defectives is also recognized.

The council notes with satisfaction the appointment of social workers to several of the larger general hospitals in Sydney, and expresses the hope that more of these workers may be attached to psychiatric out-patient departments. Twelve of the general hospitals have psychiatric out-patient departments, but only one of these departments has a full-time social worker. On the other hand, the fact that a psychiatric pavilion for thirty beds is now under construction at this hospital reflects further progress.

No results have followed as yet from the council's efforts to establish a child-guidance clinic, but the appointment of a full-time psychiatrist to the department of education will, the council believes, lead to official recognition of the need for such a clinic as well as for better provisions for backward and subnormal children. The council has also set up a subcommittee to consider epilepsy as a social and economic problem, and to formulate recommendations for the ascertainment, treatment, and special education of epileptic children and the employment of epileptic adults in special colonies or institutions.

Although the council has not attempted any publicity, its members are frequently asked to address social and other organizations outside the medical profession, and it is without doubt acquiring prestige as an authoritative body on matters concerning the mental health of the community.

Tasmania

Among the more important advances recently reported by the Tasmanian Council for Mental Hygiene are the establishment of Millbrook Home, New Norfolk, a special psychopathic hospital for the reception and treatment of incipient mental disorders; the extension of the state's mental hospital at New Norfolk and the introduction of occupational therapy and reëducation of patients; and the organization of a psychiatric clinic at the Hobart General Hospital.

The state psychological clinic is the principal diagnostic agency of the mental-deficiency board, which has power to examine all persons alleged to be mentally defective. This clinic is now used by the psychological department of the University of Tasmania for demonstrations and teaching in clinical psychology. About one-eighth of all mental defectives in the country are now in institutions under the control of the board.

The council also reports that subnormal and abnormal prisoners at His Majesty's Jail are mentally examined and appropriately dealt with according to diagnosis. Examinations are sometimes required by the courts. In this connection an interesting adjunct in the management of criminals is the indeterminate-sentence board comprising the director of public health, a clinical psychiatrist, and the governor

of the jail. All the prisoners under the control of the board undergo mental examination. This board is also, through its members, linked with the mental hospital and the mental-deficiency board.

As most of the members of the Tasmanian Council for Mental Hygiene are employed in official service, they are able to do much in their several capacities, independently of voluntary pressure from outside.

Victoria

The Victorian Council for Mental Hygiene, founded in 1930, undertook as one of its earliest activities the establishment of the Victorian Vocational and Child Guidance Center. The center functioned under a special board of management, representing the Victorian Council and the Vocational Guidance Association, and had the approval of the Victorian Branch of the British Medical Association and the Education Department of Victoria. The project was manned by a psychiatrist, a psychologist, and a social worker, and from the outset it was the policy of the founders that the center should charge fees for its services and, if possible, function on a self-supporting basis. Unfortunately, this ideal was not realized, and although the work of the center increased yearly—from 135 cases in the first year to over 500 in the third—lack of funds forced the center to suspend its activities.

In conjunction with this work for the center, the council organized a successful series of public lectures on child psychology at Melbourne University, and, with the assistance of the Australian Council for Educational Research, was able to publish the first two series in book form—namely *The Young Child* and *The Growing Child*. Various other public lectures have been arranged from time to time. In connection with the opening of the center, a member of the council undertook research into the scope for child-guidance work in Melbourne. His report was subsequently published by the Australian Council of Educational Research.

In 1932 the council took the initiative in launching a scheme for the adequate training of social workers, and subsequently established the Victorian Council for Social Training to carry out the project. This body appointed a board of social studies, which has arranged a syllabus of training, and has obtained from England a highly qualified director to supervise the actual training of students. Fourteen students have completed the course and have received their diplomas, and twenty are at present in training.

The council was also instrumental in initiating the formation of the first mental-hospitals auxiliaries in Melbourne. There are now ten of these auxiliaries, run entirely by women, and they have done

a great deal to increase the physical comfort of the patients in mental hospitals, by furnishing moving pictures, ward equipment, and other items. In addition they organize entertainments and outings for the patients. Their work is greatly appreciated by the officials of the hospitals and of the mental-hygiene department, as well as by the patients. Incidentally, the council has persuaded the Victorian Government to change the designation of these institutions from "lunatic asylums" to "mental hospitals," and the "lunacy department" has become the "mental-hygiene department," corresponding changes being made in the titles of the officers.

Much of the council's work is carried on by subcommittees. One devotes itself to problems of education in connection with mental hygiene and organizes public lectures on behalf of the council. Another is concerned with problems of mental deficiency and delinquency, and has conducted an extensive inquiry into the causes of juvenile delinquency and the best methods of its treatment. In the course of this inquiry it has obtained information from the heads of nearly all the institutions that deal in any way with delinquent children. A third subcommittee, composed of medical men, considers the early treatment, care, and after-care of the mentally afflicted. This is a creditable record of achievement, considering that almost all of the council's workers are honorary, and that the financial resources have been extremely limited.

New Zealand

The New Zealand National Council for Mental Hygiene was founded in 1929 at a meeting held at New Zealand University, Wellington, and attended by representatives of the medical profession, institutes of education, professional boards of university colleges, law councils, philosophical societies, and the heads of the principal religious organizations. The proposal to form a national mental-hygiene council was previously endorsed by the Psychiatric Section of the Australasian Medical Congress held in Dunedin in 1927.

The state mental-hospitals department was first in the field of organized mental-hygiene activity through its establishment of psychiatric clinics at the principal general-hospital centers, while the Dunedin Hospital is a pioneer in building a special ward for the observation of mental patients. A child-guidance center has been formed in Wellington under the joint auspices of this department and the school medical offices, and three psychological clinics have been organized by professors of psychology, thanks to the increasing awareness among educators of their responsibilities in regard to the mental health of children in the primary and secondary schools. So far there has been little coördination of the work done by the various

authorities in this field, and it will be a function of the national council to serve as a clearing house of information and experience with a view to coördinating these activities.

Membership in the council is limited in number to 100, but a proposal to institute a division of associate membership, with a view to widening interest in the movement, is now under consideration. The council also has in mind the institution of a New Zealand Foundation for Mental Hygiene to serve as custodian and administrator of gifts and bequests for use in financing mental-hygiene work or agencies in any part of the field. One donor already has been influenced to make a useful contribution toward the promotion of mental-hygiene education, even though the benefits of the trust will not accrue for some years. It is hoped that others will follow suit.

CANADA

The Canadian National Committee for Mental Hygiene was organized in Ottawa in 1918, as a voluntary agency to facilitate progress throughout the Dominion in the treatment and prevention of mental disorders. With an annual budget of approximately $50,000, the committee has employed a field staff for survey work and other activities, and has assisted in the funding of experimental demonstrations, research, and the training of personnel.

The committee has worked in the main with provincial governments and universities. Through contacts, encouragement has been given in the development of province-wide mental-hygiene programs, and universities have been looked to for collaboration in research and the training of personnel.

Surveys have been conducted in the nine provinces upon the requests of governments, and recommendations made by the committee have resulted in the enlargement and improvement of mental hospitals, the extension of mental-hygiene clinics, the multiplication of special classes in public schools for retarded children, and the conduct of public and professional education in mental hygiene. Thirty million dollars have been spent on capital account for the improvement of institutional and other mental-health services at the suggestion of the Canadian National Committee.

Research has been funded at McGill University, the University of Toronto, the University of Saskatchewan, and the University of Alberta. More than a quarter of a million dollars has been directed to investigatory effort and has resulted in the furnishing of valuable leads for prevention and treatment.

During the last twenty years, a comparatively small group of Canadian citizens have donated approximately $400,000 to the Canadian National Committee; the Rockefeller Foundation and the

Julius Rosenwald Fund of Chicago have granted more than $300,000; and the federal government has given an amount in excess of a quarter of a million.

The present activities of the Canadian National Committee include advisory and survey services in connection with mental hospitals, activities for the conservation of the mental health of school children, research, projects for the training of mental-hygiene workers, and the provision of a consultation educational bureau on mental-health matters.

The year 1937 was notable because of the introduction of "insulin shock" and "metrazol" therapies for dementia praecox, which constitutes, in Canada as elsewhere, the largest single institutional problem. Because of the possibilities of these newer forms of treatment in markedly reducing the burden due to this crippling disability, the committee has been actively engaged in implementing application and in fostering needed research. In this connection the committee has instituted a bulletin and consulting service to keep psychiatrists and others in Canada informed as to the most recent developments in this field in America and Europe; and a staff member of the committee is available to the hospitals of the Dominion to collaborate with workers who are utilizing insulin and metrazol.

The committee has been especially active during the past year in forwarding measures to safeguard the mental health of school children. Undertakings in this field include the compilation of a mental-hygiene manual for teachers; the publication, in collaboration with The (U.S.) National Committee for Mental Hygiene, of a quarterly magazine, *Understanding the Child,* for wide distribution among members of the teaching profession; collaboration with educators appointed by the Ontario Department of Education in the revision of the curriculum; participation in summer schools for teachers; and the making of contacts with deputy ministers of education and principals of normal schools throughout Canada in reference to mental-hygiene matters.

Another important undertaking involved a study of medical and health services in Canada, with the purpose of discovering the extent to which economic barriers and administrative weaknesses stand in the way of the rank and file of the Canadian people's receiving the attention necessary to safeguard physical and mental health. It is evident from this and similar studies in the United States that there is a great lag between the progress of scientific medicine and its translation into practical benefits for large sections of the Canadian population, and it is anticipated that the report, when completed, will present a comprehensive and significant picture

to the Royal Commission on Provincial-Federal Relations, looking toward a recasting of national policy in health matters.

Research projects of the Canadian Committee include studies of "recessive" children; a study of the mental-health needs of children afflicted with infantile paralysis; collaboration in the organization of facilities for research to elucidate physiological and biochemical factors connected with insulin shock and metrazol therapies for dementia praecox; a study of the subsequent careers of individuals who presented emotional problems when in school attendance; and the stimulation of provincial governments to include mental-hygiene and psychiatric research as an integral part of public policy, to be financed out of tax-collected funds.

GREAT BRITAIN

Among the leaflets published by the National Council for Mental Hygiene of Great Britain, which have been widely distributed during the sixteen years of its existence since 1922, is one which states: "The council has for its object the promotion of the mental health of the community. The first step towards progress is the development of a strong and enlightened body of public opinion, and this is the principal object of the National Council for Mental Hygiene."

The council has closely adhered to this objective in furthering its work. In its propaganda it has devoted particular attention to conferences and lectures as one of the foremost instrumentalities of public education for mental health. To disseminate knowledge and to do away with the present ignorance concerning mental illness, its nature and causes, treatment and prevention—such is the consistent goal of the council's educational activities.

Among these are its annual meetings; its biennial mental-health conferences, lasting from three to four days and drawing large attendances from all parts of the United Kingdom; its panel of lectures, including many of the country's eminent physicians who are always on call to fill engagements anywhere and any time; its special conferences devoted to selected topics as, for instance, occupational therapy; its semi-annual lecture courses and, more recently, an interesting innovation in the form of debates between medical and lay speakers; its quarterly periodical *Mental Hygiene;* its library and its pamphlet literature.

Lately the council has established a twenty-four-hour press service to handle inquiries and provide authoritative comments, criticisms, and corrections on mental-health matters appearing in the press. A number of leading specialists who are members of the council are available for this purpose and give their opinions anonymously on

behalf of the council. This service should prove of great value in helping to educate journalists as well as the public in the principles of sound mental health, and give the council further openings for the presentation of articles on mental hygiene of a constructive character. The council is also taking advantage of the opportunity presented by the Central Council for Health Education for participation in the Health Week Exhibitions held by that organization throughout the country.

The council has special standing committees which deal with the more scientific aspects of its aims and activities, notably research and inquiry into problems relating to mental disorders. For example, an inquiry was made in regard to the existing mental-health services of the country, and a questionnaire on the subject was sent to all county and borough medical officers of health. It was felt that such an inquiry would be valuable in indicating those areas where the council's propaganda would seem to be most needed, and in disclosing existing or projected facilities.

Considerable attention was devoted to the problem of suicide, with a view to modifying the prevailing treatment of this subject by the press. To this end the Newspaper Proprietors Association and the Newspaper Society were approached and their support enlisted in persuading newspapers to refrain from handling reports of suicides and attempted suicides in a detailed and dramatic manner. The N.P.A. thereupon circulated the council's letter on the subject to all their members, and the matter was ultimately brought to the notice of the Home Office Departmental Committee on Coroners' Law and Practice, which invited the council to send a representative to give evidence before it.

Efforts have been made to promote adequate facilities for the care and treatment of voluntary patients in mental hospitals and to encourage the wider practice of voluntary admissions under the liberalized provisions of the Mental Treatment Act of 1930. The council took an active part in the drafting of the Mental Treatment Bill, and most of its recommendations were ultimately embodied in the Act.

Another subcommittee sought to "secure for psychology and psychiatry a position in the medical curriculum more commensurate with their importance, and to further the closer association of psychology and general medicine," and drew up a memorandum on this subject when the question of revising the medical curriculum was before the General Medical Council and the British Medical Association. The association's report on medical education showed that the council's representations were considered and a recommendation was

made that psychological medicine should form an integral part of the medical student's training.

Another study dealt with the need for increasing the interest of future general practitioners in the treatment and prevention of mental diseases, and recommended that newly qualified doctors should be encouraged to take up temporary appointments in mental hospitals in the same way as they take up posts in general hospitals.

An inquiry was made as to the extent to which psychiatric social workers were employed in mental hospitals, and it was felt that the council's report of this study, which was published in various medical journals, would have valuable results and encourage local authorities to utilize the services of such workers in a larger way. Similarly, efforts were made to secure the appointment of a better type of mental nurse in institutional work and to promote better training for mental nurses.

In addition to its own program, the National Council for Mental Hygiene coöperates with such bodies as the Mental After-Care Association, the Central Association for Mental Welfare, the Home and School Council of Great Britain, the British Social Hygiene Council, the National Council of Women, the Joint Committee on Voluntary Sterilization, the Eugenics Society, the National Union of Teachers, the National Association of Probation Officers, and the London School of Hygiene and Tropical Medicine.

THE NETHERLANDS

That the mental-health idea has captured the imagination of the Dutch is evident from the rapid development of the mental-hygiene movement in the Netherlands since its founding there thirteen years ago. From the sturdy roots planted by the Dutch Society for Mental Hygiene in 1924, there has grown a network of organizations fostering mental-health aims and activities throughout the country.

An interesting aspect of this development, which is probably unique in the world-wide growth of the mental-health movement, is its association with the various church denominations under which these organizations have been established—namely, the Roman Catholic Association for Mental Hygiene, founded in 1930; the Dutch Reformed Association for Mental Hygiene, founded in 1934; and the Association for Mental Hygiene organized by the followers of Calvin in 1934.

This affiliation of organized mental-hygiene work with the dominant church groups of Holland, and the setting up of separate mental-health institutions and establishments under their respective auspices is, we are told, characteristically Dutch and has its historical

origin in the religious wars of old, though there is a unity of purpose and outlook that binds these organizations in a strong tie of friendly collaboration and mutual effort that transcends religious differences. This spirit of coöperation, growing out of the solidarity of common aims and interests as they concern mental health, subsequently found expression in the formation of a National Federation for Mental Hygiene, whose principal function is the allocation of funds appropriated yearly by the national government to subsidize and promote mental-hygiene work.

In addition to the above named organizations, there are a number of other institutions and agencies which engage in mental-health work, among them, notably, the so-called Cross Unions—the White Cross, the Green Cross, the White-Yellow Cross, and so forth—all private charitable organizations that minister to the physical needs of their beneficiaries in the rural districts. Every one of the eleven provinces of Holland has its own Cross Union, seven of these having set up a special mental-hygiene committee. The province of Zuid-Holland, where the mental-health program is most highly developed, is divided into four areas, each of which has the services of its own psychiatrist, who is assisted by a social worker (visiting nurse). Finally, there is the Central Association for the Care of the Mentally Deficient, a private organization which has established special clinics throughout Holland for the socialization of mental defectives.

An outstanding achievement of organized mental-hygiene work in the Netherlands has been the establishment of child-guidance clinics in such large cities as Amsterdam, Rotterdam, the Hague, Utrecht, Leiden, and Haarlem. The original Dutch Society for Mental Hygiene, which is non-denominational, is very active in educational work, holding many meetings each year, one of which has the character of a national congress on mental hygiene, with various sessions running for two days. Reports of these meetings are regularly printed and distributed by the society. Recently it has issued a special mental-hygiene guide, a sort of omnibus publication which contains information on all phases of the subject. A feature of the organization of the Dutch Society is the establishment of two departments dealing with special phases of its work—one for criminology and one for pedagogy.

The Roman Catholic Association is itself a federated organization, embracing all the various Roman Catholic institutions which are doing mental-hygiene work, including clinics which engage in the treatment and study of, and educational and preventive work with, the mentally ill, criminals and delinquents, the mentally deficient, and other maladjusted adults and children.

The Dutch Reformed Association conducts a series of specialized

dispensaries dealing with various social problems. One dispensary is for the mental diseases, another for the lesser maladjusted, a third for the unemployed, a fourth for matrimonial problems, a fifth for the schools, and a sixth has to do with jurisprudence, industry, the arts, and religion.

The Association for Mental Hygiene conducted by the Calvinists promotes the establishment of special clinics for mental cases and for the adjustment of family problems, and also serves an important educational institution affiliated with the Free University of Amsterdam.

NORWAY

The Norwegian Association for Mental Hygiene, founded in 1930, devotes its efforts, in the main, to the support of community mental-health services. Three "polyclinics" have been established by the association thus far: the first at Drammen and Tönsberg, the second in Oslo, the third in Trondheim.

The Drammen-Tönsberg clinic is open one day a week, with a staff of two psychiatrists, a psychologist, and a nurse, and is administered by the Lier Asylum. The Oslo clinic functions three days a week, with three psychiatrists and a nurse, under the auspices of the department of psychology of the university. The Trondheim clinic, with one psychiatrist, gives forty days of service during the year.

All of these are free clinics, the personnel working without remuneration, as the association depends on private contributions for its support and receives no financial aid from the government.

Eventually, it is hoped, the government will take over the clinics in the larger cities, thus leaving the association free to take up new activities. Though its resources are meager, it has, in addition to its clinical work, engaged in educational work, through an annual series of lectures and the publication of a periodical journal.

POLAND

The Polish League for Mental Hygiene, founded in 1935, aims to "prevent and combat mental diseases, preserve and improve the mental health of the people, and adjust mentally deficient individuals to the requirements of society." To this end the league conducts investigations into the causes of mental disorders, engages in the organization and establishment of mental-health services for children, works for the modification of social conditions detrimental to mental health, obtains employment for the mentally handicapped, and conducts advisory services on mental hygiene.

The league carries on an active educational program. It publishes a mental-hygiene journal, which is devoted primarily to the prevention of mental disorders; issues books and pamphlets on mental-health topics, and conducts contests for the production of approved mental-health literature; arranges conferences and lecture courses, mental-hygiene exhibits, and demonstrations; renders reports to government and other authorities on general questions of mental hygiene; and popularizes the principles of mental hygiene by means of suitable propaganda in the press. It also coöperates with other institutions, organizations, and agencies interested in mental-health aims, such as the Association of Polish Teachers, the Psychiatric Society, the Ministry of Justice, and so on. Recently the league memorialized the Ministry of Justice in an effort to secure preventive action against the deleterious influence of crime publicity; and it has instituted a campaign of education among physicians, teachers, and other professional bodies, with a view to spreading the knowledge and application of mental-health principles in professional, public, and private life.

SWEDEN

The activities of the Swedish Association for Mental Hygiene, founded in 1931, are twofold: educational and advisory. The association has been especially active in public education and has reached a wide audience through its lectures, conferences, and publications. For example, during a five-year period (1931–6) it conducted, largely at its own expense, over 200 lectures, chiefly in Stockholm and the surrounding district, several of which were broadcast by radio. Arrangements are now being made to extend these lectures to other sections of the country. In addition, the association has assisted in the arrangement of two-week institutes on mental hygiene held every summer at a boarding-school in Dalecarlia for the benefit of professional workers, the lecturers on these occasions usually being outstanding psychiatrists of international note coming from other European countries. The association also arranges special educational programs for its annual meetings, which are uniformly well attended.

Through these lectures and conferences the association has stimulated a widespread public and professional interest in mental hygiene and has brought about a better understanding and support of its activities. As a result, public opinion is not only better informed as to the nature and extent of mental and nervous disorders, but is increasingly alive to the importance of measures and facilities for their treatment and prevention. Special efforts have been made to enlist the interest and support of governmental authorities and

agencies. As an example of the worth-whileness and effectiveness of these efforts may be mentioned the information bureaus for the dissemination of knowledge concerning the education of backward and mentally abnormal children set up in various parts of the country as a direct result of the association's work.

These educational activities have been supplemented by the development of a series of pamphlet publications dealing with various phases of mental hygiene. In this connection the Swedish Association for Mental Hygiene has set up its own publishing organization, through which the pamphlets are printed and distributed. These publications are free to the association's members and are sold at a nominal price to all others. In coöperation with another publishing house in Stockholm, the association has also published a translation of Dr. Douglas A. Thom's book, *Everyday Problems of the Everyday Child.*

TURKEY

The Turkish Society for Mental Hygiene was founded in 1930, at Istanbul, under the sponsorship of psychiatrists, physicians, educators, lawyers, publicists, and other leaders in professional and public life. Its program includes the establishment of mental-health clinics; mental-hygiene services in the schools, with special attention to child guidance and supervision during summer vacations; family counseling, with emphasis on the prevention of marriage between the mentally diseased and defective; and public education in mental hygiene through the press and radio, publications, conferences, and lectures. The society also publishes a periodical journal.

In its educational and promotional activities, the stress is on the mental hygiene of youth and childhood, and in its contact with the country's social institutions, the society strikes the preventive note wherever possible, as, for example, in its efforts to secure the establishment of special courts for the young, special schools for delinquent children, instruction in sex hygiene, eugenic measures, and so on. Each year the society holds a national congress devoted to some special topic, as, for instance, crime, which was the subject of discussion at its last conference. In collaboration with the government, the society is also waging war against drug addiction and has secured special legislation and a vigorous program of law enforcement in this field. Similar efforts have been made against suicide, and in the interests of prevention the society has secured the enactment of a law which forbids the press to publish news about suicides, on the theory that such publicity, through the power of suggestion, is a harmful influence tending to further the evil of self-destruction.

UNION OF SOUTH AFRICA

Prominent among the more recent activities of the South African National Council for Mental Hygiene has been the establishment of mental-hygiene clinics. Such clinics were first started in Pretoria, Port Elizabeth, and Bloemfontein. After a survey of the larger centers made by the council in 1934, additional clinics were established in Durban and Kimberley. These clinics operate under the auspices of the Child Welfare Society in each center, and in the latter two cities psychiatric services are provided by the government from its mental hospitals at stated intervals. A part-time government psychiatrist has also been appointed in Johannesburg who attends the juvenile court there when called upon and attends cases requiring mental care at the jail. Johannesburg and Cape Town have local mental-hygiene societies.

The Johannesburg Society, having extended its work to include the Reef towns, has felt it advisable to change its name to The Mental Hygiene Society of the Witwatersrand. Its activities have also been extended to embrace after-care work in connection with the neurological out-patient department of the General Hospital in Johannesburg, where a representative of the society serves as social worker.

An interesting development in the Cape Province is a plan for school and hostel accommodation for epileptic children that has been approved by the Provincial Education Department and the Capetown municipal authorities, and that has the support of the Union Department of Education, which will provide funds to subsidize this scheme.

The National Council for Mental Hygiene also reports a more liberal attitude on the part of the physician superintendents of institutions for the feebleminded toward the discharge of high-grade defectives. They are more ready to parole such cases under supervision of the mental-hygiene societies, and at one institution the new policy has already been carried into effect.

The council is working for special-class facilities for the mentally defective, and after persistent representations, has finally persuaded the provincial and state authorities to appoint a psychologist from the provincial education department with a view to the organization of such classes in Johannesburg and on the Reef, with special appropriations from the Union Department of Education towards the maintenance of these classes. The council is also mindful of the need for legislation providing for compulsory attendance at special classes of children excluded from normal classes. It is also urging the appointment of a psychiatrist to the regular school medical services.

Better provision for epileptics has been further advanced by the recent establishment of a garden colony at Johannesburg, which has been subsidized by municipal and government grants. The interesting thing about this project is the fact that it has been planned for non-deteriorated and non-certifiable epileptic patients who are admitted, not as patients, but as workers, on a self-supporting basis; it provides employment to epileptics under sheltered conditions without fear of discharge if they have seizures while at work. The result has been a marked improvement, in physical health and in morale, of this class of the handicapped.

Representatives of the national council testified before a commission investigating conditions among juvenile delinquents. One result of the commission's work, to which the council contributed, has been the transfer of reformatories from the department of justice to the department of education—a gratifying move in harmony with mental-hygiene aims.

Among other objectives toward which the council is now working are the establishment of psychiatric wards in general hospitals, better accommodations for mental defectives among the native population, special facilities for colored mental cases, and child-guidance clinics. With the increased government grant recently made available to the council, which has enabled it to obtain the services of a full-time secretary, the organization hopes further to extend mental-hygiene services in the Union.

State Society News

Alabama

The regular annual meeting of the Alabama Society for Mental Hygiene was held in Birmingham on March 25. It was one of the most successful meetings of the society in years, coinciding with other events which reflected the resurgence of interest and activity in mental hygiene in the state during the past year. Participating in the meeting were members of the staff of The National Committee for Mental Hygiene who were on a field trip through the south, aiding in the promotion of various developments indicative of the increasing interest in organized mental-health work in Southern states.

A capacity audience of several hundred attended the meeting, at which the principal speaker was Dr. Clarence M. Hincks, whose address dealt with the practical applications of mental hygiene to everyday life. Prior to the meeting the society held a luncheon at which Mr. Beers talked informally and intimately of his experiences since founding the mental-hygiene movement thirty years ago.

On March 24, Mr. Beers spoke at the Alabama University Alumni Dinner in Birmingham; and at the opening session of the Alabama Educational Association's annual convention held that night and attended by several thousand teachers, he was honor guest, being introduced by Mrs. Bibb Graves, wife of the Governor of Alabama. On March 28, Mr. Beers spoke before the faculty and students of the University of Alabama at a meeting held at the university in Tuscaloosa, at which Dr. W. B. Partlow, Superintendent of the Tuscaloosa State Hospital, presided.

The following officers of the Alabama Society for Mental Hygiene were elected: *President,* Myrtle Brooke, head of the Department of Sociology of Alabama College, Montevallo; *Vice-President,* Mrs. Mary H. Fowler, Superintendent, State Training School for Girls, Birmingham; *Secretary-Treasurer,* Dr. Katherine Vickery, head of the Department of Psychology of Alabama College, Montevallo.

Missouri

The second annual meeting of the reorganized Missouri Association for Mental Hygiene was held at Jefferson City on May 1, with afternoon and evening sessions and a special program devoted to selected topics. Psychiatrists and educators discussed, among other subjects, mental health and the college student, clinical methodology in the college mental-hygiene program, the emotional problems and maladjustments of children, and economic problems of the feebleminded.

A statistical summary of activities during the past year, presented at the business session by Mrs. Helen H. Sala, executive secretary, showed the flourishing condition of the association's work under the new set-up. For example, over 8,000 persons were reached through 138 talks given by the executive secretary and by members of the speakers' bureau to various professional and public groups; 13,000 pieces of literature were distributed, including the association's periodical bulletin, *The Mental Health Observer;* 244 new members were secured; and four new branch organizations of the association were formed.

Special efforts will be made during the coming year to plant the "mental-health idea" in educational circles in the state, in accordance with a plan of action submitted at the meeting by the association's special committee on education. Among the objectives of the program will be the institution of required courses in mental hygiene for all school-teachers; publication of mental-hygiene material in the official journal of the state education association; preparation of special bibliographies for teachers in the various grades; and special educational conferences.

Dr. Frank J. O'Brien Appointed Director of New York City Child-Guidance Bureau

Several hundred leaders in education, psychology, psychiatry, mental hygiene, social work, and allied fields joined recently in paying tribute to Dr. Frank J. O'Brien, Director of the Bureau of Child Guidance of the Board of Education of New York City. The occasion was a luncheon held in his honor at the Hotel Plaza, New York City, on May 21, in recognition of his distinguished service to the school system over a period of years and of his appointment to this important new post, as successor to the late Leon W. Goldrich, first director of the bureau.

Dr. O'Brien has served as assistant director and chief psychiatrist of the bureau since 1931, when he entered the organization after ten years of specialization in child-guidance work as director of the Louisville (Ky.) Psychological Clinic, one of the pioneer organizations in this field. During the same period he was also in charge of the Bureau of Mental Health of the Kentucky State Board of Health, taught psychiatry at the University of Louisville College of Medicine, and served as psychiatric consultant to various hospitals and welfare institutions. Prior to that time he had served as a member of the survey staff of The National Committee for Mental Hygiene and had held various posts in the psychiatric and mental-hygiene field in the state of Massachusetts. He is now a member of the faculty of the Fordham University School of Social Service, and also teaches at the College of the City of New York. He is President of the American Orthopsychiatric Association.

Among the speakers at the luncheon were William E. Grady, Associate Superintendent of Schools, who presided; Miss Margaret J. McCooey, Associate Superintendent of Schools; Mrs. Johanna Lindlof, member of the Board of Education; William Hodson, Commissioner of Public Welfare; Austin H. MacCormick, Commissioner of Correction; Stanley P. Davies, General Director, Charity Organization Society; the Rev. Edward S. Pouthier, S.J., Dean of the School of Social Service, Fordham University; Miss Jane Hoey, Director of Social Service, Social Security Board; and Dr. George S. Stevenson of The National Committee for Mental Hygiene.

Vineland's Fifty Years

For half a century The Training School at Vineland, New Jersey, has been a beacon light and tower of strength to those in mental darkness whom we call the feebleminded, salvaging, training, and guiding them toward tolerable and useful lives. It has also been a center of training and enlightenment, study and research, assisting physicians, psychologists, teachers, and other professional workers with the men-

tally handicapped, illuminating the whole problem of mental defect, and influencing the care, treatment, and education of the mentally deficient in this and other countries. Out of Vineland, to quote Angelo Patri, "have come reports that have changed educational methods, educational aims, educational thinking everywhere . . . reports that have changed the viewpoint of social workers, leaders of penal institutions, hospitals, heads of institutions that deal with suffering, erring humanity."

In celebration of its Fiftieth Anniversary, and as a tribute to Professor Edward R. Johnstone's forty years of devoted service to the school, friends of Vineland have formed the Vineland Child Study Foundation to raise a fund of $100,000 through which to stabilize the support of its Scientific Research Laboratory. The mental-hygiene movement is deeply indebted to Vineland, and friends and supporters of the movement can discharge that debt by contributing to this fund and thus assure the continuance of this vital work. Gifts should be sent to The Vineland Child Study Foundation, The Training School, Vineland, N. J.

Survey of Letchworth Village

How New York State is providing for the rehabilitation of its mentally defective wards is discussed in the revealing and instructive report of a survey of the methods of care, treatment, and training of the feebleminded at Letchworth Village, one of the leading institutions of its kind in this country. The appraisal, made by a committee of experts, with funds provided by Mary E. Davidson and the Milbank Memorial Fund, is made up of nine individual reports, covering the physical layout of the Village, the architecture, sanitary provisions, mechanical equipment, soil conditions and farming, the care of the patients, educational procedures, administration, and the statistical and research program. Letchworth Village was opened in 1911, and at present has about 3,600 patients.

In summarizing the report, Dr. C.-E. A. Winslow, who served as chairman of the survey committee, attributes the success of the institution in its first quarter century to its establishment as a "village" rather than as a "custodial asylum"; to the use of one-story buildings instead of the barracks type of construction used in other institutions; to the hopeful attitude expressed toward trainability and restoration to the community of those susceptible of marked improvement; and to the recognition of basic scientific research as a fundamental responsibility. He paid tribute to the State Department of Mental Hygiene for its wise guidance and development of the institution; to the late Dr. Charles S. Little, as a great executive who directed

the institution from its inception; to the board of managers for its unique vision and devotion; to Franklin B. Kirkbride, Letchworth's "vital mainspring for all these years"; and to Mrs. E. H. Harriman, who made the research department possible. With the continuance of such leadership, Dr. Winslow said, "the story of Letchworth's second quarter century should be as significant as the first." A limited number of copies of the report are available for free distribution. Requests should be addressed to The National Committee for Mental Hygiene, 50 West 50th Street, New York City.

1936 Census of Mental Defectives and Epileptics

The Federal Census Bureau, in a summary of its latest annual enumeration published recently, gives the total number of mental defectives in state institutions in the United States on December 31, 1936, as 76,651, with 12,898 additional patients on parole or otherwise absent. There were 7,656 new admissions to these institutions in 1936, the increase in resident patients during the year being 2,143.

Epileptics in state institutions on December 31, 1936, numbered 16,352, with 1,843 additional patients on parole. New cases admitted in 1936 numbered 2,099, the increase during the year being 408.

In addition to the above, there were 5,162 mentally defective and epileptic patients in city and private institutions on the same date.

Hopeful Results of Insulin Therapy

In a statistical study of the outcome of insulin treatment of 1,039 patients with dementia praecox in the New York state hospitals, Dr. Benjamin Malzberg, Senior Statistician of the State Mental Hygiene Department, reports 679 of the cases, or 65.4 per cent, showing some degree of improvement. Of these, 134 patients, or 12.9 per cent, were reported as recovered; 282, or 27.1 per cent, as much improved; and 263, or 25.3 per cent, as improved. In a corresponding group of 1,039 patients who did not receive insulin treatment, only 22.1 per cent showed any degree of improvement after a hospital residence of from one to two years. In other words, the rate of improvement among those treated with insulin was almost 200 per cent in excess of the rate among those not so treated. It was also shown that rates of recovery and of improvement were highest among those patients who had received treatment early in the course of the mental disorder. The hope was expressed that later reports will show that the good results of insulin therapy are permanent in most cases. If so, the new treatment will have important social and economic consequences to the state.

A New Psychiatric Periodical

With the publication of No. 1, Volume 1, February, 1938, *Psychiatry, Journal of the Biology and the Pathology of Interpersonal Relations,* makes its appearance as a new medium for the interchange of thought in the mental, biological, and social sciences. Dedicated to the memory of the late Dr. William A. White, for many years one of the foremost exponents of scientific psychiatry, the new magazine is the creation of the William Alanson White Psychiatric Foundation, which was established to perpetuate his work and to advance the study of human relations, in their personal and situational aspects, in line with the newer and broader orientation and concepts of psychiatry that Dr. White did so much to develop. According to the prospectus, the journal is directed "not alone to psychiatrists and psychiatric research personnel in the narrower sense, but to all serious students of human living in any of its aspects, and to those who must meet pressing social needs with current remedial attempts." It is a quarterly periodical, each number containing up to 150 pages of original communications, reports, surveys, reviews, and abstracts, and sells for $6.00 a year. Subscriptions should be sent to the Foundation at 1835 Eye Street, N.W., Washington, D. C. The first issue includes, among others, the following articles: *Psychiatry: Introduction to the Study of Interpersonal Relations,* by Harry Stack Sullivan; *Why Cultural Anthropology Needs the Psychiatrist,* by Edward Sapir; *Unrecognized Antagonisms Complicating Business Enterprise,* by Ernest E. Hadley; *What Psychiatrists and Political Scientists Can Learn From One Another,* by Harold D. Lasswell; and *Mental Hygiene and the Class Structure,* by Kingsley Davis.

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